They Won't Say Die by ALTON L. BLAKESLEE

today's health

JANUARY 1952 35c

The Growing Polio Problem

Health on the Budget

Preview of Birth

PUBLISHED BY THE AMERICAN MEDICAL ASSOCIATION

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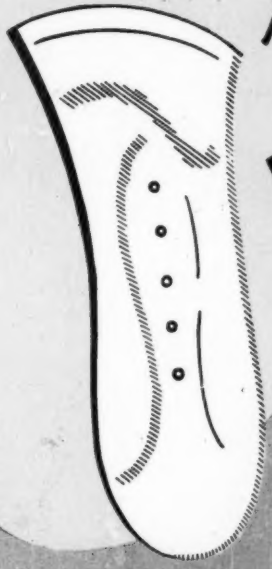

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JANUARY 1952

VOL. 30 • NO. 1

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That's a good question

Edited by WILLIAM BOLTON, M.D.

Nails and Vitamins

Question. For several years I was troubled with my nails splitting and peeling back from the edges. Finally, this spring, I discovered that if I ate a lot of citrus fruits my nails stopped shredding. For a while I stopped taking the fruit, and the nails got bad again. Do you think this is really a factor, or just coincidence? Would it be the vitamin C that helped to keep my nails from shredding?

Ohio

Answer. In nail disorders like this, physicians always recommend an adequate diet without special emphasis on any one vitamin. There is a strong possibility that by eating more fruit you improved your general nutrition. Both vitamins C and A help prevent excessive dryness of the skin, especially in the winter, but neither can be considered curative treatment.

Approved Way of Brushing Teeth

Question. Could you please tell me what is the approved way of brushing one's teeth? What type of tooth brush is best?

New Jersey

Answer. According to literature issued by the American Dental Association, a six-point routine should be followed in brushing the teeth. First the chewing surfaces of upper and lower teeth are brushed, next the inner surfaces of upper and lower back teeth, the inner surfaces of upper front teeth, inner surfaces of lower front teeth, outer surfaces of upper and lower back teeth, and finally the outer surfaces of upper and lower front teeth. Inner and outer surfaces should be brushed vertically, away from the gums. A medium-sized tooth brush is recommended for adults, and a small one for children. According to the American Dental Association, it should always have a flat brushing surface and two or three rows of medium stiff bristles with six or seven tufts of bristles in each row.

Smoking and Drinking

Question. I read in a newspaper recently a statement to the general effect that if a person with coronary heart disease wanted to smoke it probably would be a good idea to take a drink at the same time, the idea being that alcohol would offset any narrowing of the blood vessels that might be caused by nicotine. What can you advise about this? Do you think it would work in my case? I had an attack about six months ago, and have been under a doctor's care off and on.

Connecticut

Answer. It is true that the practice mentioned was suggested recently, but further investigation has cast considerable doubt on its reliability. Reports in the medical literature have stated that alcohol does not dilate the coronary blood vessels, and it is suggested that what alcoholic drinks do chiefly in these patients is lower their sensitivity to the pain produced by such attacks. This would be undesirable, because the patient would not be inclined to relax as he would ordinarily when such pain occurs. It is best for coronary patients to rely on the advice of their physician. In some, moderated smoking may be permissible. No general statement can ever be made to cover every situation, but since neither tobacco nor alcohol is essential to life perhaps the best decision is to abandon attempts to balance one against the other, and give up both.

Lung Collapse

Question. I have often wanted to know something about pneumothorax treatment for those suffering from tuberculosis. Is the treatment practiced successfully to any great extent? I have known several persons who claim to have been cured by the treatment, but have known others who seem to suffer from complications. Many develop "fluid" in the pleural sac. Is that due to irritation from the treatment, or to the disease itself?

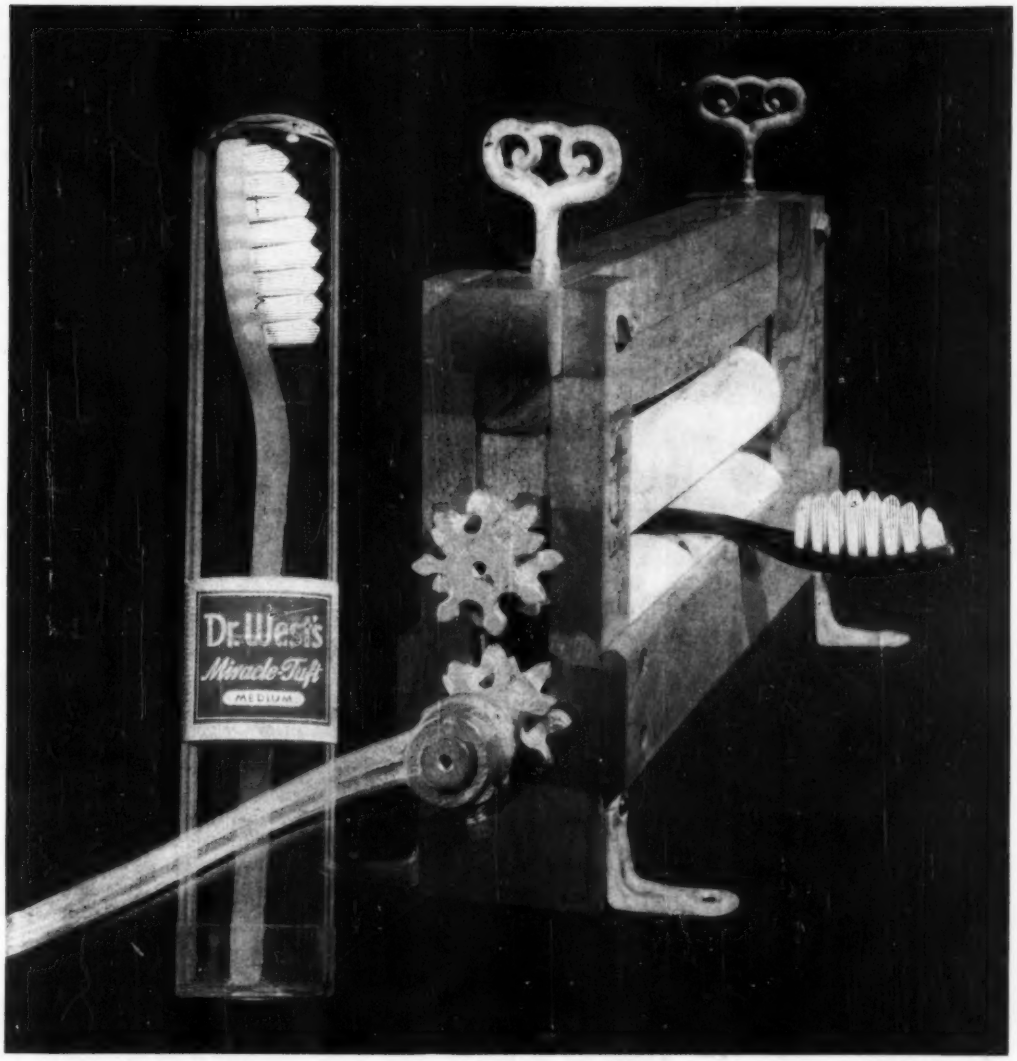
Washington

Answer. Artificial pneumothorax, or lung collapse, is now being generally practiced by physicians who specialize in the treatment of pulmonary tuberculosis. It consists of the introduction of an innocuous gas, such as atmospheric air or nitrogen, into the chest cavity. This causes the lung to collapse—to shrink down toward its "roots," while the blood supply is materially diminished. The lymphatics are likewise put out of action, so that there is less absorption from the diseased spots in the lung. Cavities are also compressed and tend to become much smaller.

If there have been attacks of pleurisy, collapse of the lung may be incomplete because pleurisy frequently leaves areas of the lung stuck to the chest wall.

Air thus introduced into the chest cavity is absorbed and must be renewed at regular intervals. However, as the treatment progresses, the intervals between fillings become longer, so that, whereas the fillings at first are only two or three days apart, they are made at intervals of three or four weeks after the treatment has been well established.

The appearance of fluid is not in



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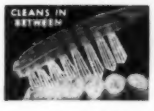

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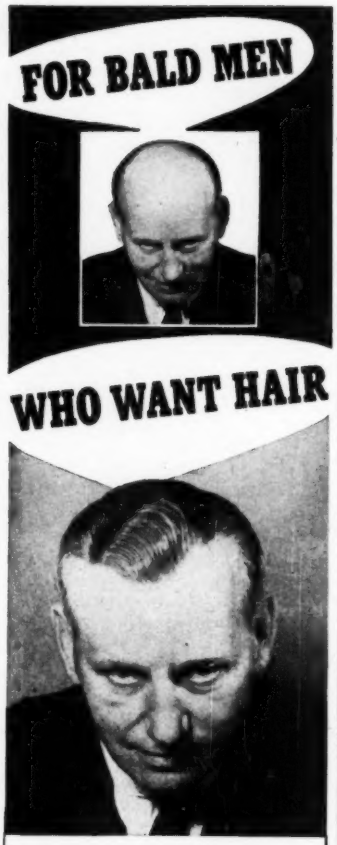

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itself an element of danger. In fact, not a few physicians find that those cases which have developed fluid do better, in the long run, than those which have not had this complication. Fluid is probably the direct result of the presence of air in the chest cavity. All in all, lung collapse has earned a place in the successful treatment of pulmonary tuberculosis.

Answers given here are limited to brief replies to specific questions. Full discussion is not intended. Questions involving diagnosis or treatment should be referred to the family physician. Dental inquiries are answered through the cooperation of the American Dental Association.

Two things remain to be said: cases must be carefully selected for treatment, since not all are suitable, and the patient must not expect that he will have the use of his collapsed lung again. He is fortunate even if his collapsed lung remains forever lost; he can work with one lung collapsed, if the other one is well. So many persons have been returned to good job-holding capacity through this means that the place of artificial pneumothorax in the treatment of pulmonary tuberculosis is not questioned.

Blood Donations

Question. Because of the interest in blood donations, I would like to ask what occurs when one gives a pint of blood, and whether this might have any harmful effect. I am somewhat nervous, and although I would like to make a donation I wonder whether this would be wise. I do not have any physical disability. What percentage of the total does a pint of blood represent?

Pennsylvania

Answer. The effect of donating a pint of blood is simply a slight and temporary drop in the hemoglobin concentration of the donor's blood. It is the same as that produced by blood loss in any other manner, except that no physical harm is associated with a donation. The blood is removed painlessly under sterile conditions. It has been reported that the hemoglobin concentration is made up within a week, but agencies receiving blood do not take "repeats" for at least six weeks to two months. Nervousness is not in itself an important reason why one should avoid donation, for many people with minor manifestations of "nerves" are in good health. But blood is not often taken from nervous people. In spite of the fact that no harmful effects are produced, sometimes a nervous person can imagine that undesirable changes have been produced.

There are about ten pints of blood in the average adult body, and therefore a pint would represent aproximately one-tenth of the total.

Operation for Angina Pectoris

Question. I have angina pectoris. I have heard of an operation in which they put powder in the heart sack. Can you tell me about this, and also about the cost? Is there any special hospital where it is done?

Illinois

Answer. This operation is one of several ways to improve the circulation of the heart muscle. Decrease in the heart's blood supply, due usually to narrowing of the arteries supplying the heart, is the cause of the typical heart pain known as angina pectoris. The basic principle of the operation is the fact that when the surface of the heart is irritated with powder or in some other way, new blood vessels develop in the area. This brings additional blood to the heart muscle. Of course no specific recommendations can be made until a thorough study has been carried out in each case. The operation is not advisable for every patient with angina pectoris. No special hospitals employ this form of surgery, but specialists in chest and heart surgery are now practicing in many parts of the country. We feel sure your doctor knows of such specialists and can refer you to one for consultation.

Hair Loss

Question. My hair is thick, but dry and coarse. On the back of my head there is a round bald spot about the size of a half dollar. And I haven't any eyebrows or eyelashes.

What could you recommend to restore this hair loss? Most of my family has little or no hair, and my mother has no eyebrows or eyelashes. Do you think my condition is hereditary? Pennsylvania

Answer. Your description of the hair loss from your scalp strongly suggests the condition known as alopecia areata, although it is obviously impossible to make any diagnosis without examining you. In this condition, a series of hairless areas may appear. The prospect in alopecia areata, however, is always encouraging because normal hair growth will return without any special treatment. The information about loss of hair from the eyebrows and eyelids is not sufficient to permit any conclusion. If this condition has been present for several years in your case as well as that of your mother, heredity might be significant. Consultation with your doctor, however, would be necessary to determine this. In the skin disorder known as seborrhea, patchy loss of hair from the eyebrows often occurs.

Aspirin in Canning

Question. Some women here use aspirin as a preservative in canning raw apples and unpeeled tomatoes. Does aspirin destroy any food value? Illinois

Answer. Acetylsalicylic acid (aspirin) has only feeble antiseptic properties on a limited number of micro-organisms. It acts more as an inhibiting agent than as a killing agent. It certainly could not be depended on to rid a canned food of the rugged organisms so often responsible for food poisoning. In most cases its toxicity to the consumer would be negligible, but aspirin has the undesirable feature of causing distressing and often alarming symptoms in people who are particularly sensitive to it.

For proper home canning, therefore, careful attention should be paid to sanitary precautions and adequate methods of heating, since aspirin or other chemical preservatives do not guarantee a product free from harmful organisms.

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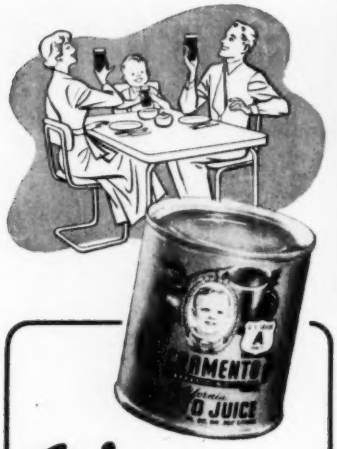

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By Carl J. Potthoff, M.D.

A new lifesaving technique—an improvement on the well known Schafer prone pressure method of artificial respiration—is now endorsed by the Red Cross and other organizations after intensive investigation. The method, called the back pressure—arm lift method, is recognized as the most effective way to revive victims of drowning, electrocution, suffocation and other common mishaps. Dr. Potthoff explains the standard technique for administering it in his First Aid column next month.

I'M PREPARING TO RETIRE

By Annie Laurie Von Tungeln

It's never too early to start preparing for your "last career"—those years after 65 which many people dread to face. Here, from one of our most observant authors, is a formula for happiness, with suggestions on how to plan now so that your retirement years will be fruitful and enjoyable.

FLUORIDES AND TEETH

By Frank C. Cady, D.D.S.

Don't be alarmed if Junior should some day announce that his teeth have been "washed off with florals" at school. It will mean that a dentist has swabbed his teeth with a fluoride solution—thereby making them more resistant to decay. That's one of the ways scientists have devised to make fluorine's special benefits available to all children. A few communities have a natural supply of fluoridated drinking water, and about 140 cities now inject the magic drops artificially. An authority on public health and dental science gives you the interesting facts on this promising development.

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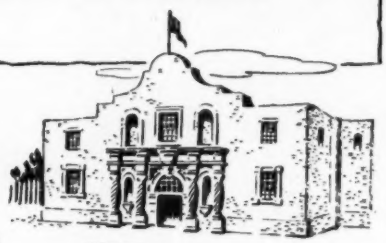

The war for Texan Independence produced this stirring cry that still rallies citizens of the Lone Star State.

On February 23, 1836, 4000 Mexicans under command of Santa Anna laid siege to the Alamo and its 180-man garrison. After a furious thirteen day battle, the Texans were slaughtered in a final hand-to-hand struggle. Santa Anna's victory was short-lived, however, for a band of Texans, shouting their new war cry, and led by Sam Houston, defeated and captured him at San Jacinto on April 21, 1836.

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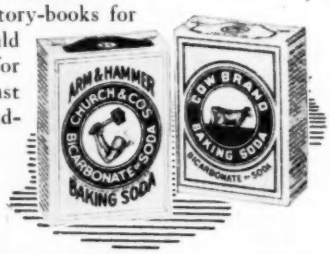

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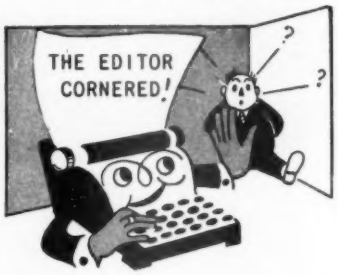
BUSINESS ESTABLISHED IN 1846



HEALTH education in a democracy presents some interesting, peculiar and, at times, frustrating viewpoints. There can be small doubt that health education in the broadest sense has produced a great deal of good. Health education is not merely the efforts of health educators in the classroom and through books, magazines, speeches, radio, television, exhibits or person-to-person contacts. It includes every experience that has any bearing on health. Prominent in the list of these experiences is advertising.

Some modern types of advertising have grown increasingly blatant and insistent, while others have gained in beauty and dignity. At times, one can hardly get away from the claims pressed on us by the promoters of a wide range of merchandise and services. When the length of a radio or television commercial becomes excessive and its content and tiresomeness insult the intelligence, it ceases to make sense—or sales. It makes one feel like the irate citizen who made a list of people he was going to bite, in case he ever got rabies. Radio offends in the same manner as television, if to a lesser extent. Advertising on the printed page seems more reserved, or perhaps it is merely easier to get away from.

When all these complaints about advertising have been placed on the debit side, we must in all fairness look at the credit column of the ledger. The modern food industry, with its frozen and canned foods and its distribution of fresh foods under refrigeration, has to a large extent erased the seasonal variations in the nation's diet. It has promoted and increased the use of milk and dairy products, of meats and other proteins, of fresh fruits and vegetables. It has introduced us to the

dainties and tidbits of other nations and has helped give variety and interest to our food.

The place of the orange on the breakfast table and elsewhere in the day's diet is not due solely to recognition of its food values and to persuasion by health educators; we eat the number of oranges we do largely because of distribution and promotion by the citrus industry. The orange is but one case in point. Similar advertising for meat, dairy products and other fruits and vegetables has in like manner increased production and consumption, and in so doing has created millions of jobs and contributed to the prosperity of the nation.

Advertising is not accorded sufficient credit for its numerous benefits, while it is criticized freely for its relatively few shortcomings. All this is preliminary to a sort of mild remonstrance from me to some of our readers, who seem over-critical with regard to advertising. I am not going into detail, because every critic has been answered individually.

The point I want to make here is that no advertisement appears in *Today's Health* unless the advertising staff, the editors and the advertising committee of the American Medical Association are satisfied as to the integrity of the product and the manufacturer. These expressions probably will not meet with universal approval. There are some who are convinced that all soft drinks and all candy must be condemned. Others conceive of health education as a series of edicts from the godly heights of a health-education Olympus, and do not realize that in no area of personal conduct—even alcohol, tobacco and sex—can we make rules for the other fellow. We can only present the facts and let every responsible person make his own choice. The teacher who hides a health magazine, because it contains one article of which he does not approve, thereby betrays a lack of faith in his own leadership and a lack of understanding of democratic principles.

We like readers' complaints, for they stimulate us and keep us con-

(Continued on page 11)

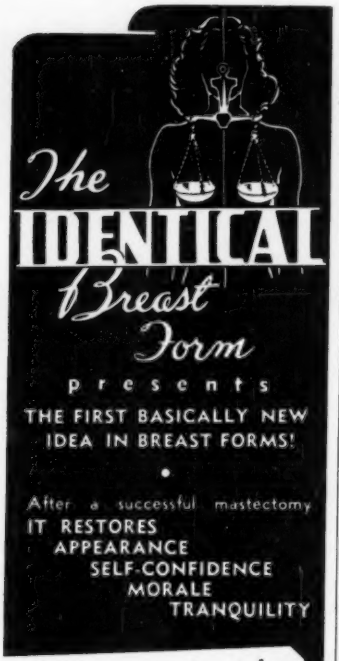
New cream deodorant stops perspiration worries completely . . . doesn't dry out in the jar!

FRESH contains the most highly effective perspiration-stopping ingredient now known to science.

FRESH is a smooth cream that doesn't dry out in the jar. It is never greasy. Never gritty. Never sticky. Usable right down to the bottom of the jar.

FRESH never lets you down—try it yourself . . . you'll see why more and more women are switching to **FRESH**

Fresh is accepted for advertising in publications of the American Medical Association



Climate and Asthma

Question. I am considering moving to another location because for the last eight years my 12 year old son has suffered from severe, chronic asthma. Have you any statistics on the relative beneficial effects of the climate in various parts of the United States? West Virginia

Answer. Before you move to any new location, it would be wise to determine exactly what is responsible for your son's asthma. Climate alone will not be a cure for asthma or any other disorder. If, for example, your son is allergic to a substance such as house dust, you can appreciate that moving somewhere else would not help.

If your son suffers from ragweed allergy, however, removal to an area where there is relatively little ragweed pollen would probably be beneficial. If you plan to move, you should obtain information from local officials regarding the prevalence of substances to which your son is allergic.

There are specialists in this field, known as allergists, in virtually all large population areas. If your family doctor cannot refer you to such a specialist, you can obtain names of allergists from your local medical society.

Potato Skins

Question. Is it harmful for a perfectly healthy 3 year old child to eat the skins of baked potatoes? I have been told their continued consumption might bring on colitis. My child does not eat more than the skin of one potato every other day. Michigan

Answer. If the child is perfectly healthy, the skins of baked potatoes are not likely to be harmful if not taken in excessive amounts. There is no reason why the skins of baked potatoes should be more likely to produce colitis than other coarse foods. If the skin of a small baked potato is eaten by a normal child not oftener than every other day, it should not be injurious.

Blood Sedimentation Test

Question. Is there much importance attached to an increase in the blood sedimentation rate of a child with rheumatic fever? Could you explain how this test is made? California

Answer. In the blood sedimentation test, a small amount of blood is quickly mixed with a solution that prevents coagulation. A portion is placed in a small, graduated tube held upright. The red blood cells, being heavier, will slowly sink to the bottom of the tube. The rate at which this precipitation occurs is timed, and can be read at any interval by the markings on the tube. When the rate is increased, that is, when the blood cells settle out more rapidly than usual, this is considered suggestive of some body abnormality. Although it is not the only evidence that should be sought in rheumatic fever or any other dis-

order, it is of value in helping the attending physician decide the degree of activity of an infection. As the rate of sedimentation becomes slower, it usually means that the acute condition is subsiding. If a flare-up occurs in the disease, the sedimentation rate may increase.

Eye Growth

Question. To settle an argument I should like to know whether the eyeball grows after birth. Does it change in shape at all?

Colorado

Answer. The eyeball continues to grow after birth, just as most other organs in the body do. This growth is rapid during the first year of life, and continues at a slower rate until the eighth or ninth year, when it reaches adult size. In the first years the anterior-posterior growth rate somewhat exceeds the rate at which the eyeball expands above and below, but ultimately the diameters have about the same relative proportion. In the newborn, the eyeball measures about 16 millimeters (about three-fourths of an inch) from front to back and 15.5 millimeters up and down. In the adult the measurements are about 24.5 and 23.5 millimeters.

Dental questions are included here through the cooperation of the American Dental Association. *For* Child Training *see page 68.*

The Editor—Cornered

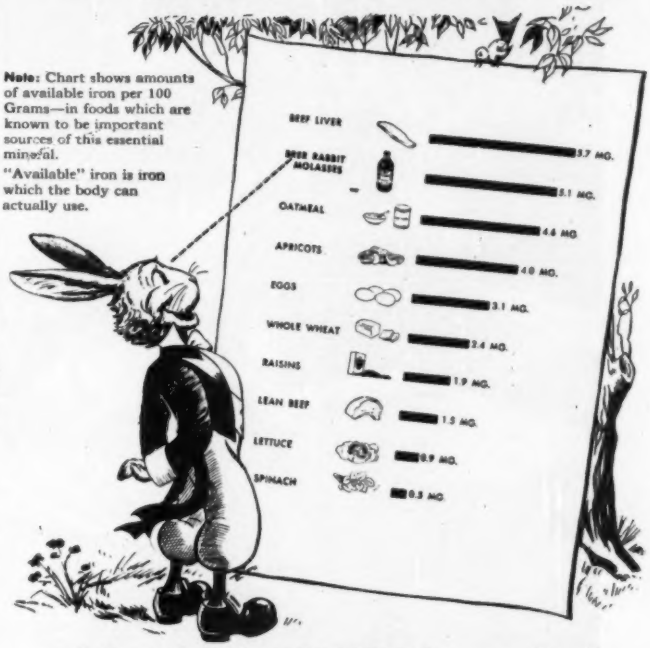
(*Continued from page 9*)

stantly examining ourselves to be sure that we are right. When we disagree with your view, it is because we believe that we have the weight of scientific facts and experience on our side and not merely because we happen to be sitting in the seat of authority. If you send us enough constructive suggestions, we may even establish a column for publishing them; we have an aversion to letters composed exclusively of syrup and honey.

And letters from subscribers help to keep the Editor . . . CORNERED.

W. W. BAUER, M. D.

IRON IS NEEDED for good red blood!



and Brer Rabbit MOLASSES is second only to liver in available iron content

Without good red blood to carry oxygen to the brain, heart, lungs, liver . . . the body organs cannot do their work efficiently! Without good red blood, we cannot be *healthy!*

So it's a wise mother who sees that her family gets Brer Rabbit in some form *every day*. Especially the youngsters — because children (and expectant and nursing mothers) have a *special* need for an abundance of food iron.

Use sunny-rich Brer Rabbit as a spread on plain or buttered bread, over pancakes and waffles. Use it in flavorful gingerbread, cookies and other baked goods. (None of the iron richness is lost in cooking.) For a delicious milk shake, rich in iron and calcium—simply add one or more tablespoons of Brer Rabbit to a glass of warm or cold milk.

ONLY 3 TABLESPOONS

of Brer Rabbit a day will supply about one-third of an average person's iron needs. Can you imagine a more pleasant and *economical* way to add this essential mineral to your family's diet?

Write for FREE Recipe Book today!

For over 100 grand tested recipes, send your name and address to: PENICK & FORD, Dept. TH-5, New Orleans 7, La.

Gold Label Brer Rabbit is light, mild-flavored.

Green Label Brer Rabbit is darker—full-flavored.

ACCEPTED FOR ADVERTISING IN PUBLICATIONS OF THE AMERICAN MEDICAL ASSOCIATION

Made by the Makers of My-T-Fine Desserts and Vermont Maid Syrup

There's No Place Like Home

(To Select Your Cosmetics)

A miss is as good as a mile when you are selecting cosmetics. We suggest that a sure way to satisfaction is to try before you buy. The obvious place to do that is in the unhurried privacy of your own home. There, on your invitation, a trained Luzier Cosmetic Consultant will help you select the perfect combination of beauty aids for your particular needs.

Luzier's, Inc., Makers of Fine Cosmetics and Perfumes

GIE

KANSAS CITY 3, MISSOURI

HERE'S WHAT WE THINK

VD IS STILL A PROBLEM

IN the last few years we have heard a great deal about the use of penicillin in the treatment of venereal disease. Wishful thinkers have jumped to the conclusion that VD is a thing of the past, or shortly will be.

The truth of the matter is that, while penicillin will rapidly cure most cases of syphilis and gonorrhea, we still have an enormous VD problem. Last year alone doctors reported 476,775 cases of VD. The American Social Hygiene Association estimates that at least as many more cases remained untreated, or were treated too late to prevent them from being, for months or years, a source of infection to others.

Penicillin can cure most VD, but it cannot find infected people and persuade them to accept treatment. It cannot prevent the infected from transmitting VD to others. And it cannot prevent those treated and cured from getting VD again and again.

Our primary job is to prevent the sexual promiscuity, especially among young people, which leads to infection.

How do we prevent promiscuous behavior?

By recognizing that we can't substitute medicine for morals.

By telling every person, young and old, of the dangers of VD and of the necessity for prompt treatment, should infection occur.

By accepting the fact that each of us is responsible for protecting the strength of marriage and family life.

By providing sound character-training for children and young people.

By protecting young people from prostitution and exploitation.

By vigorously supporting the police in their efforts to repress the "third party" interests who make money out of the prostitution racket.

JEAN B. PINNEY

MEDICAL PROGRESS AND ORPHANS

IN this period of increasing divorce, it is comforting to note that fewer homes are broken through the death of a parent. Today the chance of a child's becoming an orphan is half what it was in 1900.

The greatest mortality decrease has been among mothers. The chance of a child's losing his mother at birth is only one-eighth to one-seventh that of a generation ago. Of 371,000 children under 18 who lost a parent in 1948, only about one-third, or 132,000, lost their mothers. Often the father remarries.

Loss of the father is even more significant economically. The younger the father at death, the longer the mother must provide both home and income for her children until they become self-supporting. In 1948 91,000 children lost fathers under 45, 82,000 lost fathers 45 to 54, and 67,000 lost fathers over 55. The majority of these fathers were middle-aged. This means fewer years of double work ahead for the mother.

The social benefits of medical progress are nowhere more evident than in this decrease in the proportion of orphans.

FRANK G. DICKINSON, PH.D.

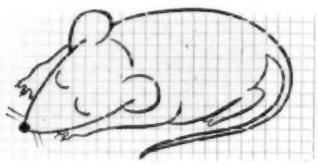
WHAT DO YOU THINK?

today's health News

by ALTON L. BLAKESLEE

SLEEPY-TIME AID

Looking for a chemical short cut to make the hormone cortisone, researchers for a manufacturer found that one of their preparations put mice to sleep. They switched the target to work on sleeping pills, and finally came up with one that seems to put most people to sleep in half an hour. It's an entirely new kind, free of opium, barbiturates or bromine. Some hospital patients took it for months. They didn't get addicted to it, had no "hangover" the next morning, no bad effects, said physicians who tested it. It doesn't affect the pulse or breathing rate, and it disappears from the body in two hours or so, after inducing natural



sleep. Apparently no one could use it to kill himself—he couldn't take enough. A liquid in a green capsule, the sleep "pill" is available only on prescription. It's not a pain-reliever, and won't replace sleeping pills which are used partly for that purpose.

HIDDEN TB

Half a million Americans have TB, the National Tuberculosis Association estimates. But 250,000 of them aren't known as yet to health authorities or in most cases to the victims themselves. Partly this is because there are no obvious signs of TB in its early stages. Locating these TB unknowns is one activity of the TB associations, which depend heavily upon your Christmas Seal purchases.

SO IT'S COLD OUTSIDE

Like to stay warmer in cold weather? Clues may come from knowledge of how animals put up with bitter cold. Dr. Dan H. Campbell of the California Institute of Technology is studying the blood chemistry of Arctic squirrels, which hibernate in Alaska with body temperatures near freezing, in hopes of learning how a species of animal common to the temperature zone manages to adapt to Arctic deep-freeze.

HOPE vs. THE BOMB

At last there is real hope of curing or preventing radiation sickness from atom bombs. This optimistic view replaces the pessimistic outlook of a year ago, says Dr. Franklin C. McLean of the University of Chicago. One clue is the spleen research of Dr. Leon O. Jacobson of the same university. Juice pressed from the spleens of normal mice was injected into other mice after they had received ordinarily deadly doses of x-rays. Thirty per cent survived, indicating that there is something in the spleen that aids recovery from exposure to radiation. Dr. Jacobson's experiments promise us "a breakthrough in the search for methods of treatment," in Dr. McLean's view. Meanwhile the known aids to recovery include antibiotics, blood transfusions, drugs to control bleeding and treatment to correct damage to normal blood formation.

UN-COMPLICATION

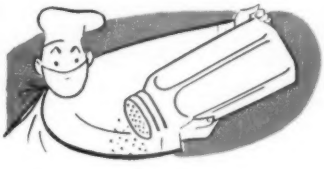
Adhesions forming after abdominal operations are a worry. In animal experiments, the hormones cortisone or ACTH reduced the number of abdominal adhesions produced by using talcum powder as an irritant, Drs. Schayel R. Scheinberg and Harry C. Saltztein of Detroit report in the *Archives of Surgery*.

The dosages employed didn't interfere with wound healing.

LESS BOUNCE

Medical reports tell of reactions from penicillin—fever, skin rashes, swellings in joints, and other troubles—in 5 to 15 per cent of people taking the wonder drug.

Now comes a new form of peni-



cillin, in a special salt, that seems to control or prevent many such allergic kickbacks. Less than one per cent of 2000 persons taking it had reactions, early clinical tests showed. One physician finds it can usually be

taken all right by people sensitive to other penicillins, and that it even apparently controlled reactions in some who already had them.

INSIDE THE HEART

Surgeons at Montefiore Hospital in New York have taken the first movies ever made inside the living heart, in this case the heart of a dog. An artificial heart detoured blood around the whole left side of the heart. The heart kept pumping, though free of blood on one side, to make the color action films possible. They show the closing and opening of the mitral valve, between the upper (auricle) and lower (ventricle) chambers, and tell new details about this valve and the heart action. The facts are expected to be useful in treatment and surgery of heart conditions, especially in rheumatic fever in which the mitral valve can be damaged by scar tissue.

HEADACHE RELIEF

In migraine headaches, ergot plus caffeine brings relief in 90 per cent of cases, Dr. Lester S. Blumenthal reports. He is chief of the headache clinic at George Washington University Medical School. Several forms of ergot work against headache, but they are safe only when prescribed by a doctor.

NEWS OF CANCER

Cancer of the appendix isn't a rarity, Dr. Robert J. Sillery of New Orleans writes in the A.M.A. *Journal*. He finds 116 cases reported in the last few years. Usually the cancer isn't discovered till the appendix is removed for other reasons.

An A.M.A. study *finds no benefit from krebiozen, a drug announced last spring as showing promise against cancer and cancer pains. Of 100 patients getting it, 98 showed no signs of improvement and two had perhaps temporary benefits, said the A.M.A.'s Committee on Research of the Council on Pharmacy and Chemistry. Forty-four of the patients had died at the time of the writing of the report.*

Cancers sometimes disappear by themselves, it seems. At the annual meeting of the American Cancer Society, Dr. James W. Reagan of Western Reserve University told of six cases of cancer of the cervix that apparently went away, with no treatment. They were very tiny, in very early cases, detected by cell smears. Biopsies were made in some of the six, with the verdict of cancer. Later on, the cancers couldn't be found or detected, even as long as 17 months afterward.

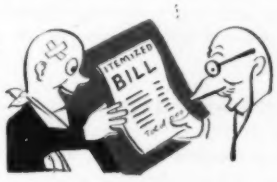
Such events are rare, and no one should gamble on this mystery or delay one moment in getting treatment if cancer is detected.

Another puzzle was discussed by Dr. Paul F. Fletcher of St. Louis University School of Medicine—the fact that localized tiny cancers may remain sleeping in one spot for three to ten years before invading elsewhere.

A synthetic female hormone, diethylstilbesterol, may offer a weapon against cancer of the cervix. Dr. H. E. Nieburgs of the Medical College of Georgia, Augusta, said four tiny localized early cancers had apparently disappeared following its use. Similar cancers in two other women changed toward normal. Two women with advanced cervical cancer felt better. To date, these results are interesting, but they certainly can't be regarded as a cure, he said. It's too early to warrant using the hormone generally in such cancers.

ITEMIZING

Would it make you happy to get a garage bill saying only, "Repair on 1948 car—$64.32"? The Illinois State Medical Society thinks you'd prefer the bill itemized for labor, parts, and services. It urges doctors to consider itemizing their own bills, listing night calls that the patient may have forgotten, or why the bill totals as it does, rather than making it simply for "services rendered."



LOVE BIRDS UNLIMITED?

The Public Health Service proposes relaxing of federal restrictions on importing and interstate

shipment of love birds, parrots, parakeets and other members of the parrot or psittacine family. Reasons: While these birds carry psittacosis or parrot fever, other birds do, too, and, anyway, the disease no longer is a major public health problem. Antibiotics hit it effectively. Enforcing present regulations costs more than they're worth.

DRUG TRIO

Three new and closely related antibiotics from fungi or molds are under test by a pharmaceutical company. One is said to show promise against tuberculosis in animals. The TB germs apparently don't become resistant to it, as with streptomycin.

MENTAL BLOOD TEST

A brand new kind of blood test may be able to spot people with serious mental illness, and help measure their improvement under treatment. In first trials at Creedmore State Hospital in New York, it's been more than 80 per cent accurate in differentiating between known psychotics and normal persons.

It appeared that the blood of most mentally ill clots differently from blood of normal people. The test detects the differences by using sound waves of such high frequency that

the human ear can't hear them. The energy of these sound waves is absorbed by the blood sample, and a machine records the physical changes.

The test is under careful study, for it has many possibilities and implications in mental illness. One intriguing aspect is using sound as a means of spotting blood changes in illness. There's a chance this method might be useful in other diseases, too, such as cancer or even heart trouble.

CHAIRS, NOT BEDS

Instead of strict bed rest, Dr. Samuel A. Levine of Harvard Medical School suggests chairs to aid recovery of many heart patients. Sitting upright, he says, assists them by preventing blood from collecting in the lungs, due to unequal pumping of blood by the two sides of the heart. Writing in the *American Heart Journal*, Dr. Levine tells of some remarkable improvements in patients with congestive heart failure and coronary thrombosis when they spent as much of the day as possible sitting in chairs. Psychologically, the chair treatment also seems better than being told to lie still in bed.

MELTER SHOT

Now there's an injection to "melt" swellings that come from bruises or broken bones. The melter is hyaluronidase, a natural enzyme of the body. The medical supply comes from the testes of bulls. A movie,

made under direction of Columbia University's College of Physicians and Surgeons and Presbyterian Hospital, shows how it works. Tight-fitting casts can be put on fractured limbs. The enzyme, acting like an oil, also spreads the anesthetic given by dentists, and relieves the pain of some kinds of medical injections. The film was produced by a drug firm.

A report in the *Glasgow Medical Journal* also finds hyaluronidase useful, to aid in cutting free skin grafts.

BABY NOTES

If a baby's eyes remain crossed at the age of six months, there's a

strong chance that he won't simply outgrow the trouble. The infant should be started on corrective treatment, Drs. Robert M. Trueman and Joseph A. Ritter of Philadelphia told the American Academy of Pediatrics. In a quarter of all affected babies, the cross-eyedness is temporary, they said. But babies don't outgrow established crossed vision. Eyeglasses or surgery can correct the trouble.

If mothers eat more protein during pregnancy, their babies are healthier, Dr. William J. Dieckmann, University of Chicago obstetrician, informed the American Dietetic Association. A diet high in meat also helps prevent spontaneous abortions or miscarriages.

HEALTH IN THE SERVICES

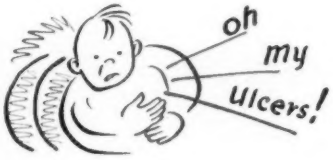
Diseases now cause fewer non-battle casualties among men in military service than do vehicular accidents, reports Dr. Lowell T. Coggeshall, dean of the division of biological sciences, University of Chicago. Control of diseases has advanced steadily, in effect giving our armies extra divisions of men because they are not taken out of action by sickness as much as in former years and former wars. But jeep, truck and other vehicle accidents still are a serious unsolved problem, in military as well as in civilian life.

FLUORINE AND TEETH

In a number of cities, fluorine is being added to drinking water, for it seems to promote better, more decay-resistant teeth in children. But the fluorine effect apparently is nullified or blocked if there is too much magnesium in food or drink, Dr. Albert E. Sobel, biochemist of Jewish Hospital, Brooklyn, reports. He found this effect in studies on rats. Maybe, he adds, a little more phosphorus-bearing foods in the diet would block off the magnesium.

ULCERS IN THE YOUNG

Stomach ulcers even pick on children. Drs. James F. Martin and Henry F. Saunders, writing in *Radiology*, say there are at least 18 recorded cases of gastric ulcers in children, most of them discovered during surgery. They tell of a boy, 6, who was found by x-ray studies to have an ulcer. He went on a diet for ulcers, and did nicely.



SAFER PLASMA

Storing blood plasma at room temperature seems safer than cold storage of it, unless the plasma first is sterilized, Dr. J. Garrott Allen, University of Chicago surgeon, told the American Association of Blood Banks. Room temperature appears to kill the virus of jaundice, which sometimes is present in blood plasma. Freezing can preserve it. And room temperature hastens the death of viruses that cause rabies, polio, smallpox and mumps, he said.

GREEN NAILS

Fingernails can be turned to various shades of green by infection with fungus organisms, usually various species of *Aspergillus*. Green nails may also be caused by other yeast-like organisms and one kind of bacteria, Drs. Morris Moore and Morris D. Marcus of St. Louis report in the *Archives of Dermatology and Syphilology*.

GERMS FIGHT BACK

Against the "Wonder Drugs"

Sometimes they even thrive on the very medicine that's given to destroy them.

by WILLIAM BOLTON, M. D.

GERMS—those invisible bits of life that are all around us—have at least one significant quality. They never give up. This will to live may be shown in many different ways; by the ability to hibernate for long periods; to withstand drying or intense cold, to change their living habits, even to alter their basic characteristics.

Striking evidence of the adaptability of germs is now being presented to medical scientists in connection with treatments where the sulfa drugs and antibiotics are employed. Both research workers and practicing physicians have seen startling manifestations that have serious bearing on our fight against disease. Although it would be wrong to say that the "wonder drugs" have failed us, it is becoming increasingly necessary to avoid their casual use and be alert to possible need of a change in the attack.

Unless these warning signs are heeded, it may be that patients will be a little better off in the cure of a few disorders, but much worse off in the broad spectrum of disease.

The reasons for this changing concept are summarized by a prominent English bacteriologist, Dr. Lawrence P. Garrod, in a review of his own findings and those of many other scientists in America and elsewhere throughout the world, published in the *British Medical Journal*. Dr. Garrod's review cites three ways in which germs may fight back when the sulfa drugs or antibiotics are used against them.

One of these ways has had repeated confirmation in the experience of practicing physicians, and convincing evidence is accumulating in respect to the others. Briefly, in certain infections, sulfa drugs and the various "powerhouse" antibiotics may be entirely inadequate, and in some instances it may be far safer not to use them.

Commonest of the three counter-attacks by which germs ward off the legal punch of drugs, according to Dr. Garrod, is the development of specific resistance. That is, a certain sulfa drug or antibiotic is highly effective for the patient at first. Most of the invading micro-organisms are killed off. The catch is in the "most of." For some reason, perhaps inability of the drug to reach certain germ colonies in high concentration, a few germs survive. And their partial exposure teaches them to grow in a different way, so the drug no longer harms them. This new defensive quality is passed on to succeeding generations, and as it is passed it increases in effectiveness. Obviously in a relatively short time that particular sulfa drug or antibiotic will not be of much help to the patient.

Numerous reports of this phenomenon have appeared in medical literature. It was graphically illustrated in a study made at a Naval training center near the close of World War II. In an attempt to lower the number of colds and nose and throat infections, doctors gave all personnel at the center daily doses of sulfadiazine. This part of the program was highly effective. But after a time an unexpected complication developed. It was found that during the same period there had appeared a sulfonamide-resistant strain of gonococcus; the percentage of cases in which this treatment was ineffective rose rapidly from 30 to 70.

Because that experience has been repeated many times over with many different types of germs, physicians have introduced special treatment tricks with which to outwit their foe. For example, in any case where it is suspected that such a situation is developing, careful laboratory check is kept on susceptibility of the infecting organism to the drug being used. If resistance increases, the physician can (*Continued on page 66*)

Paints and paste are fun, and they help a child's expression and growth if he is not strait-jacketed by adult standards.

What art means to children

by RYERSON VERVAET

KATHY, 4 years old and bursting with energy, tore into the classroom at New York's Museum of Modern Art and hurled herself at a chair. "I'm so glad it's art day," she exclaimed, picking up a large paint brush and splashing vigorously at the paper laid out on the table. Eleven other children, less exuberant than Kathy, followed her in. They were ready for their weekly adventure with paint, clay and collage.

For the next hour and a half, I watched the art teacher smilingly assist her charges. Her guidance was by suggestion rather than direction.

"I don't think that picture is quite finished, do you?" she asked Kathy. The excited child, after two swipes at the paper, had declared that she was "finished."

Curly-headed Janice worked painstakingly on one painting for 25 minutes. The teacher offered her clay, and Janice pounded on it with obvious relief. During the hour and a half period, each child had a try at all the materials, and each had an interested look at the reproductions casually placed around the room.

These 3 and 4 year old youngsters don't know it, but they are learning as they play. They are discovering for themselves differences in shape, color and texture, and they are expressing what they themselves see and feel. Because they enjoy using the materials, they feel responsibility for them and help take care of them.

Later, when they begin school, they will read more quickly because they are trained in visual discrimination. They will write more easily because of dexterity gained with a paint brush. They will react responsibly and creatively to school problems because they are accustomed to carry a task to its conclusion.

What about children at home? Are they also learning as they use their crayons and color books? No, say art education authorities. Color books are a tight, uninteresting medium; using them, the child has neither fun nor freedom. As he painstakingly fills in the lines in the color book, he is completing an adult's ideas, not expressing his own. He is denied the thrill of discovery that a four year old feels as he exclaims, "Look, I made pink!" Even a sense of accomplishment is missing; the picture is not really his. Color books are little more than exercises in neatness; they do not provide the variety and interest which children, with their short attention span, need.

Children vary, as adults do, from day to day and hour to hour. Sometimes they are ambitious; sometimes they need the reassurance of "easy" material. Kathy, in the class I visited, needed stimulation to concentrate her wandering energies; Janice needed satisfaction. Kathy finally settled down to work a difficult collage construction, while Janice was glad to leave her painting for the less taxing medium of clay. Crayons and colorbooks cannot possibly fill all these needs, but they are inexpensive and easy to acquire. One day I decided to see just how difficult it would be to set up a real home art kit.

For an hour and a half, I ransacked the attic, the workshop and the dime store. When I finished I had collected enough painting, collage and clay equipment to supply my two children for a month. I had spent six dollars, most of it for basic items that could be used over and over. The amount seemed a little steep until, at the end of the month, I realized that the children had not asked for anything else. They had been too busy with their art set to want the incidental toys they ordinarily craved, and then ignored after a day or two.

"It makes such a mess," one mother complained when I told her about my experiment. But, when I ushered her into the children's room, she changed her mind. Karen and Gay, wearing smocks, were busily engaged on a "project," and they and their equipment looked very neat. There were no drips on the floor. Tin trays catch them at the source, and brown wrapping paper takes care of the rest. Karen paints on an easel made by thumbtacking one end of a roll of wrapping paper

on the wall and unrolling it far enough to catch paint which might stain the floor. Gay uses a low table, also covered with paper. My husband's Army footlocker is serving a new and happier purpose; all the big equipment fits into the bottom section, and the tray holds the glue, paper, scissors, scraps of wood, cloth and miscellaneous items the children use for collage or cutouts. My friend expressed even more surprise at the end of the afternoon when the girls came down to tell me they had put away their materials. A week later she called to tell me what a fine time her children were having with *their* art kit!

It would be pleasant if parents could buy their children equipment and feel that they had done their whole duty. But Mother's and Father's attitude is more important than adequate materials. Many children will never really express themselves in art because their parents react in one of two ways. Some praise extravagantly; others ask, "What is it, dear?" Both are wrong.

Children know that everything they do is not "beautiful." If we say it is, they may suspect us of insincerity and lack of interest. And overpraise may block a child's progress.

Nancy, age 8, painted one picture over and over. Her art teacher could not understand it. Nancy was intelligent and imaginative, and the picture was handsome. Why couldn't she invent anything new? Finally it was discovered that she was suffering from overpraise. The year before she had been awarded a prize in another class for the very same picture. Her parents were delighted. They had the picture framed, and hung it over their living room fireplace. Nancy felt unable to live up to that past accomplishment; never, she thought, could she do anything to equal it. So she kept on painting it. When her teacher talked with her about the way she had used color and design and the methods that had captured her mood, instead of extolling the picture itself, Nancy went on to paint new subjects.

This does not mean that parents should not show pleasure at their children's work. It does mean that they should not take it too seriously, for, if they do, their children will grow self-satisfied and unable to progress, or doubtful of their parents' honesty. Children's pictures are not masterpieces; no child has either the control or the experience to produce great art, no matter how much their abstractions may resemble, to the inexperienced eye, the famous modern primitives. Children's pictures are part of growth and learning. They are charming fragments, testimony of the child's stage of development, and they should be treated as such. Hang your children's paintings, but change them from week to week and don't feature them as major decoration.

Johnny, youngest of three, had just received his first paints. He spent a delightful half hour swirling color onto paper, discovering how it looked when he twisted his paint brush and what happened when he mixed yellow and blue. He brought his paper proudly to his mother. "Why, Johnny, what is that?" she inquired. Johnny's face fell; he didn't know what it was, and suddenly his wonderful picture seemed silly. "Why don't you paint a picture of our house?" his mother suggested, her eyes and her mind on the kitchen

clock. Johnny went upstairs slowly. He painted the house, but it wasn't much fun. When his older brother and sister came home from school, they said it didn't really look much like a house.

Johnny missed a lot. He missed the fun and the accomplishment of expressing his own ideas instead of his mother's. He missed the satisfaction of doing something all his own, something no one else could do better. His brother and sister could paint a house that looked more real than his. They could always do things better than he.

Little children like Johnny seldom paint realistic pictures by choice. The world of the printed page has not yet claimed them; they react to life visually, in terms of shapes and colors rather than in terms of words and stories. Their paintings are just as likely to express emotional experience as literal experience if they have not been taught that they should paint exactly what they see. Sometimes this can be a great help.

Martha, age 4, was taken to see a dramatization of "Jack the Giant-Killer" in which the giant was so gruesome that she was terrified. For weeks she woke screaming from nightmares in which he figured. Finally she took control of him, and a large, face-like shape began to appear in her paintings. In each picture he became larger and more awesome, until one day he was a ludicrous caricature of ugliness. That day she laughed at the giant and showed him to her classmates, and she never painted him again. She had won the battle of fear.

Martha's story is unusually explicit, but something similar happens with every child who has paints and art material at hand. Art is as good an escape valve for the normal child or adult as occupational therapy is for the mentally ill. After a mood or a problem has been expressed in clay or paint, it often disappears. A charming and mature woman I know always keeps a clay head on her mantel. After a trying day, she takes it down and works furiously on it. When her husband and children come home, she is smiling and serene. A further advantage in this case is that her husband can tell at a glance when his wife needs pampering!

Parents, too, can learn a good deal about their children's personalities and moods from the art they produce. But they should be wary in their interpretations. They should remember that they are not trained psychologists. Overuse of blue, for instance, has been publicized as a symptom of maladjustment. But an

ordinarily cheerful child may be influenced by a morning's mood, or he may be experimenting with new colors. His parents most certainly should not rush him to a doctor just because his painting that day is conceived in somber hues.

The best way for a parent to gain insight into his child's personality through his art is to observe his attitude as he works. In children's art, it is the process rather than the product which counts. A mother who wanders in and out of the room, or who allows her child to paint in the kitchen, can gather a good deal of useful information about him. Does he stab at his paper as though it were a mortal enemy? Or does he reflectively mix colors in the true scientific spirit? Is he relaxed or tense? Her own attitude of interest and encouragement can do much to help him work out his problems.

Children who grow up with the opportunity to look at fine pictures will not only produce more imaginative art themselves, but will develop instinctive taste and discrimination. This is one of the few real gifts that parents can give their children. A yardstick with which to judge the true and the false, the good and the bad, is an invaluable possession. At the end of this article is a list of fine paintings that most children like. It was assembled by Victor D'Amico, educational director of the Museum of Modern Art in New York, and other specialists in art and child psychology. It is worth your attention. Parents can also clip magazines and collect postcard-size reproductions for use on the family bulletin board. In a family where art is lived with and enjoyed, children will soon pick up the habit and make reproduction collections of their own.

In this article I have made no attempt to distinguish between the talented child and the untalented one. There should be none. Art and art enjoyment are a neglected part of growth and learning that every child should have. Art should be as free and joyful an expression of the growing personality as singing and dancing. With children who are not inhibited by copybook rules, it is.

When the time comes, each child will decide for himself whether he is talented or not. The child who expresses himself easily and who loves the medium will continue to paint or work in clay. Other children will turn to music, words or figures. But all will have gained—in perception, enjoyment and expression.

AN INEXPENSIVE ART KIT

Here is what the author collected for her children. You will find useful articles in your own attic and cupboards—others can be bought in an art store or the five and ten.

For Painting:

- **a smock**
- **an aluminum tray or cookie tin about 9 by 14 inches and ½ inch deep, to hold equipment**
- **a plastic bowl for water**
- **a one inch flat bristle brush**
- **a half inch flat bristle brush**
- **six glass furniture coasters to hold paint**
- **six half pint syrup dispensers for paint storage and to ease pouring**
- **tempera or show-card colors: black, white, blue, red, yellow and green**
- **white drawing paper, 18 by 24 inches, or newsprint**

For Collage:

- **colored construction paper**
- **mucilage with a rubber top dispenser**
- **scissors (rounded ends for young children)**
- **scraps of wood of various shapes, sizes and thickness**
- **corks of various sizes**
- **wire of different gauges**
- **cloth and fur, feathers, colored straws, cellophane—anything that children like, can cut, paste or bend**

For Clay:

- **gray moist clay (available at any art store)**
- **small wooden tray or board**
- **tongue depressor or popsicle stick**

Fine Paintings for Children

The following reproductions are suggested for children 3 to 8 by the Committee on Art Education, sponsored by the Museum of Modern Art:

"Before Entering the Ring" by Camille Bombois, "For Internal Use Only" by Stuart Davis and "The Sleeping Gypsy" by Henri Rousseau. (Museum of Modern Art, 11 West 53 St., New York)

"Poody" by Ray Euffa, "Farm Scene" by Ruth Gikow, "Children Skating" and "Nancy and Co." by Riva Helfond, and "In the Jungle" by Dora Kaminsky. (National Serigraph Society, Serigraph Galleries, 38 West 57 St., New York)

"Cow Jumping Over the Moon" by Chet La More, "The Peaceable Kingdom" by Edward Hicks, "Barnyard" by Mervin Jules and "Landscape with Yellow Birds" by Paul Klee. (Raymond and Raymond, Inc., 40 East 52 St., New York) And "The Yellow Donkey" by Paul Klee. (F.A.R. Gallery, 746 Madison Ave., New York)

The reproductions range in price from 25 cents to $10. Inquiries should be addressed to your local dealer or to the gallery indicated.

Self inspection against **cancer**

by ROBERT D. JOHNSON, M. D.

TITLES are often tricky. Let me make this one clear. It would be foolish to think that anyone could determine the presence of cancer in himself by some simple method. There is no simple method, even for the physician. On the contrary, it takes careful investigation by a trained technician to learn for sure whether a growth is cancer, and even he must lean heavily on the tools provided by the labors of thousands before him.

The key to our title lies in the words "self inspection." This you *can* do. You, even better than a physician, can look for certain cardinal signs and symptoms commonly seen early in cancer. Yes better! You are in a position to see them every day and at their very first appearance. You can discover the very first indication of a cancer—if only you recognize the sign as it stands before you. Roughly one person in eight will die of some cancer. This should certainly arouse your personal interest.

I will enumerate some of the signs of cancer of which you should be aware. But first let me make two things clear. These signs are not in any sense absolute. They can occur in many other conditions. Their presence does *not* mean cancer. Their presence *does* mean that you should seek competent medical evaluation. Second, a certain modest per cent *will* be cancers, early ones made even earlier, we hope, by your intelligent suspicions. Everybody knows the cures are primarily the "early ones."

Consider first the skin as a site for cancer. Skin cancer is not common in young people but it does occur. Moles situated where they are frequently irritated should be removed, especially if they noticeably grow, become darker, bleed or fail to heal after irritation. Older people who develop any kind of sore that does not heal in two weeks should suspect cancer.

Our gastrointestinal tracts are common sites for cancer. A sensation that food "sticks on the way down," with or without vomiting, should encourage one to investigate the esophagus and upper part of the stomach. Cancer of the stomach is one of the more difficult cancers to detect early, mainly because the patient often does not feel ill in its early stages. Being a large bag for temporary storage of food, the stomach may harbor cancers that grow to considerable size before they interfere with its mechanics, unless they involve the inlet or outlet. Then they may cause repeated vomiting, occasionally of blood, because of the obstruction.

The vague symptoms that may mean stomach cancer might include nothing more than a sense of fullness shortly after eating a not too large meal, discomfort in the stomach or indigestion soon after eating or perhaps occasional or frequent black bowel movements. There are several causes of black bowel movements, including medicines containing iron or bismuth, but black stools from bleeding are characteristically black as tar and sticky, and they have an extremely foul odor. Frequent abdominal cramps, diarrhea alternating with constipation, bright red blood in the stools or stools ribbon-like in shape are all signs deserving further investigation. Taking for granted that all bright red bleeding from the rectum is due to hemorrhoids or "piles" may let a bleeding cancer in the rectum just above them get a deadly hold.

You have probably seen a goiter, an enlargement of the thyroid gland in the neck just below the Adam's apple. Goiters rarely become cancerous, but recent studies show that one type has a greater incidence of cancer than all the rest. It is not the kind that shows a uniform generalized enlargement, nor the kind with

many nodules or lumps, but rather the type with a single, sometimes small, nodule or lump. Of these glands with a single nodule 10 per cent become cancerous. This may occur at any age but especially in young people. It is now the concensus that all thyroids with a single adenoma or lump demand serious consideration for surgical removal.

The obvious signs of a possible cancer of the respiratory tract are principally persistent hoarseness and coughing. Cancer of the larynx or vocal cords, because it thickens the cords on which it grows, produces hoarseness and lowers the pitch of the voice. Consequently a good rule to follow is this. See your doctor for any hoarseness that lasts over two weeks. He will examine your vocal cords with special apparatus and you can be reassured there is no serious cause for the symptom or, if he finds anything wrong, something can be done about it immediately.

Symptoms of cancer in the lung are often due to the obstruction or closing off of one of the smaller branched

You have a better opportunity than even your physician to note the earliest signs of several common types of cancer.

breathing tubes called bronchi. This may produce shortness of breath, but more often the earlier and more important sign is a cough—a persistent, irritative, at first non-productive cough, which may later produce sputum streaked with blood. The important thing for you is to have persistent coughs investigated.

Cancers of the breast can certainly be found earlier if every woman will examine herself once or twice a month. The most favorable time is about five days after the regular menstrual period when the slight enlargement of the breast, normal at that time, has waned. A correct method of self examination cannot be described adequately in this limited space. Have your family physician demonstrate the method for you. I will, however, emphasize one or two key points: Use the flat of your palm; do not pinch the breast between your fingers —you can find "lumps" in any breast that way but you will be feeling the normal ducts and glandular tissue. Instead compress the breast against the chest wall with the flat of your opposite hand while reclining. A lump will strike your palm as a stone in your shoe strikes your sole. Do not neglect the upper outer section of each breast nor the area underneath and below the nipple. A second part of the examination should include inspection of the breasts before a mirror while going through prescribed motions and observing any dimpling or irregularity of contour. Bleeding of the nipple should, of course, make you suspicious.

One might say with justification that every woman past 25 should have a pelvic examination every year. But even if this were done, and we know it isn't, it would not be enough. Suppose you get a clean bill of health in January. It is entirely possible that before your next annual examination much could happen. You see, even on the yearly basis, a close enough watch cannot be kept. But no one is closer than you to tell-tale signs. If you know them, your suspicion may be aroused so that you go to the doctor before the year is up. Then and there he can reassure you that nothing is seriously wrong (which is the usual case); or he can immediately start action to remove the invader while there is still time—because *you* suspected it early.

There are several causes for irregular menstrual periods, but they, as well as excessive menstrual flow, clotting with menstruation and spotting between periods or after intercourse, should be investigated. Spotting, of course, means even one or two drops of blood at any time but the regular period. Of even greater import is spotting or frank bleeding after the menopause or "change of life" is complete.

Cancer of the prostate gland in men, the gland that surrounds the opening leading from the urinary bladder, gives few early signs. But, if it is a good rule for any woman over 25 to have a pelvic examination every year, it is as true that every man past 35 should have a rectal examination once a year, for the prostate gland can be examined quite easily through the rectum. Especially if the man is having difficulty initiating the urinary stream or has noticed definite decrease in force or calibre of the stream, he should be examined by his physician. Nearly all these cases will be only a benign enlargement of the prostate, but a rare one may be early cancer.

Kidney cancer is not common, but it occurs, and sometimes in young children. Cancer of the bladder, however, is not too unusual in older people. The sign to watch for here is blood in large or small amounts in the urine. It may or may not mean cancer. But don't wonder—now is the time to be sure.

Finally, two other general signs and one specific sign must be mentioned. First, unexplained persistent fever; second, persistent weight loss; and, third, any bone pain that could be described as boring and is worse at night.

Other types of cancer exist, it's true. I certainly have not covered them all. But it is my belief that you are in a unique spot. You have a "box seat" at the most important game of your life, the game *of* your life. The symptoms that I have mentioned may give you that important advantage in the successful treatment of cancer, the factor of time. They may bring you to us, your physicians, so we may bring you the best in medicine—in time.

HOW WE LEARN TO SEE

A scientist's clear statement of some little known facts and what they mean to the care of your eyes

WE usually assume that a newborn baby can see because it opens its eyes and "looks about." Newborn kittens cannot do this for about a week. Thus we conclude that a kitten is blind whereas we can see at birth. But let us examine this case closer. Strictly speaking, a newborn baby is also blind, because it cannot recognize objects and forms. At least we may call it blind if we also agree to call those persons blind who cannot distinguish objects even though they may have the faculty of discerning light from dark in the same manner as we do with closed eyelids. The newborn reacts to light merely by turning away or closing his eyes if the illumination is too bright. It has not yet acquired the ability, called fixation, to look at an object directly. The eye movements are aimless and uncoordinated.

But, beginning with the first day of life, the infant rapidly builds up his world of seeing, a process which actually never comes to an end as long as eyes and mind remain receptive. The first step in learning to see consists of the fixation of objects in the line of view. Most infants achieve this ability within five weeks. Only when an object is looked at directly and followed by the eyes does it form a clear image on the light-sensitive layer of the eye background, the retina.

The image is thus actually formed within the eye. Nevertheless we do not see the objects as lying on the retina. They appear to be outside of us. The most fascinating learning process of our early infancy is that we acquire this ability to see objects *in the external world* and do not sense them on our eye background.

It is primarily the earlier maturing sense of touch that helps us to develop this ability, the power of orientation. By the sense of touch the baby first "discovers" his own hands and feet and then the ball he is holding. In time he correlates the retinal image of the ball with the touch of the ball outside of his body. Naturally he cannot learn to project the objects into the external world any farther than the reach of his limbs. No object, no matter how distant, can appear to the baby farther away than the length of his arm. In other words, his horizon is like a soap bubble with the radius of an arm's length. All objects beyond this horizon are equally far, distant objects appearing small and closer ones large. The baby reaches for the moon which appears to him just as far and big as a ball above the cradle, but gradually, with increasing activity, he widens his horizon.

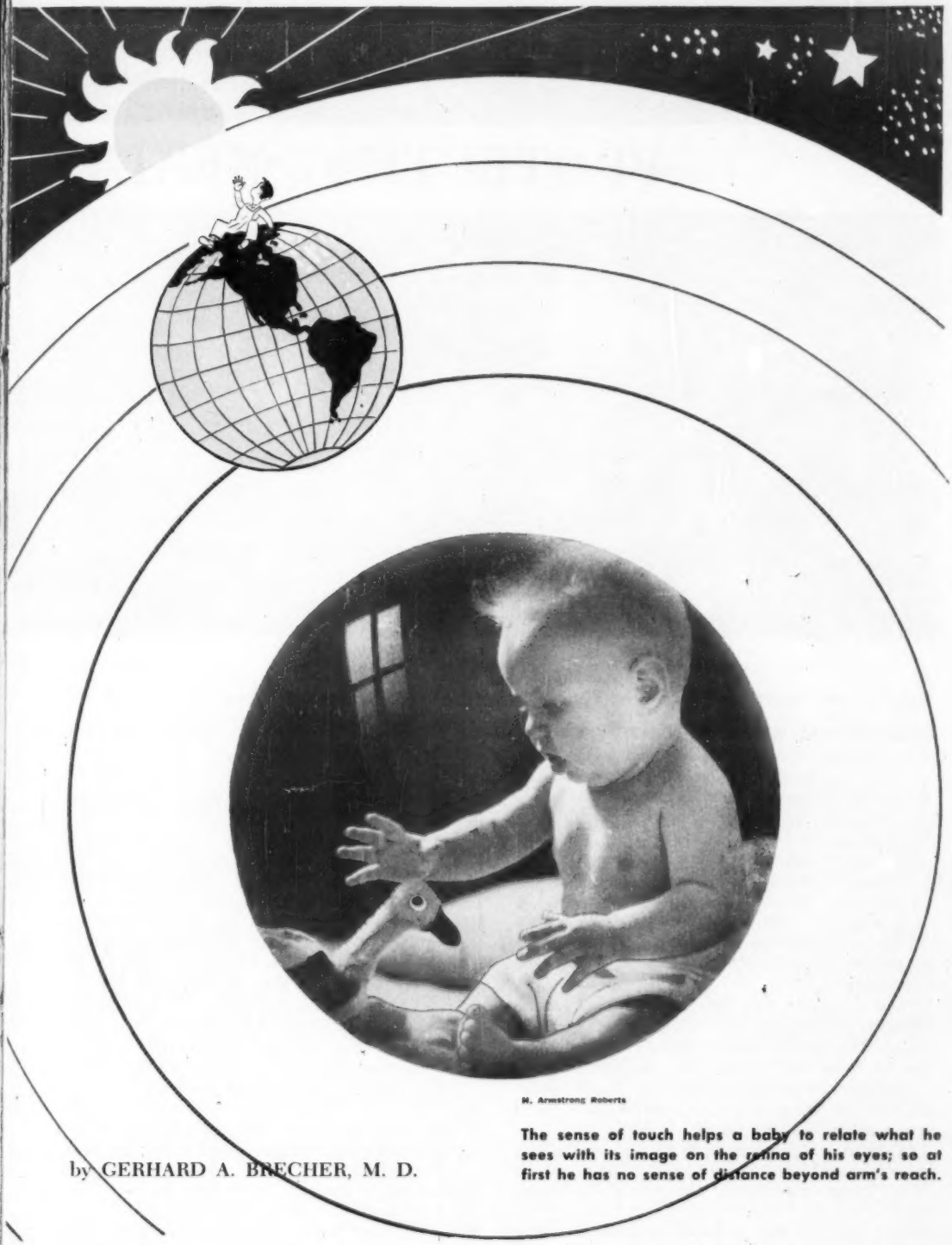
It takes him about six months to acquire the power of orientation. About the same time he begins to coordinate the movement of both eyes more precisely. This is necessary in order to achieve proper binocular vision, the art of seeing with both eyes. Utmost precision in eye coordination is imperative to project the optical images of objects on exactly corresponding places of the eye backgrounds. Only if the position of both eyes is properly adjusted do we become capable of accurately perceiving depth and distance. It takes children about six years to master the art of binocular vision and depth perception. But some never learn to see with both eyes. Most people who have good binocular vision do not realize its value until some defect occurs.

Under ordinary circumstances we are not aware of the fact that an object—let us say a pencil—creates two similar images on the background of our eyes, one on the retina of the right eye and one on the left. Since each eye sends its nerve impulses separately to the brain, one might suppose we should see one pencil with each eye. In other words, we should see everything double. But a normal person perceives only the one pencil because the twin images fuse in the brain into one inseparable unit. Nearly a hundred years ago, the great physiologist Ewald Hering said that we see with both eyes as if we possessed one in the middle of the forehead such as the Cyclops described in Odysseus' adventures.

Single vision is possible only when the position of both eyes is coordinated by reflex. The reflex which brings this coordination is called the fusion reflex. Its action can be easily tested by pushing gently at the side of one eyeball. This dislocates the eye and unbalances the muscular coordination so that for a moment "the Cyclopean eye falls apart" and objects appear double.

Some people who never learned to fuse the retinal images mentally suppress the image of one eye. They see only with the "dominant" eye. In others who do not have strong fusion power, double *(Continued on page 58)*

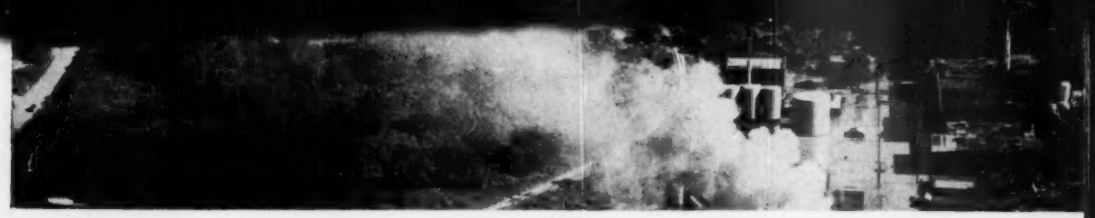
Dr. Brecher is a research physiologist at Western Reserve University School of Medicine.



M. Armstrong Roberts

The sense of touch helps a baby to relate what he sees with its image on the retina of his eyes; so at first he has no sense of distance beyond arm's reach.

by GERHARD A. BRECHER, M. D.



PROTECTING HEALTH

How a city marshals its forces to care for the victims and prevent epidemics—as witnessed in last year's Kansas City flood.

I LIVE in Kansas City. I happen to be one of the many thousands of fortunate people who live outside the areas stricken last year by flood and fire. But because Kansas City is my city, this disaster stunned me, as it did my neighbors. Night and day, we huddled near our radios. Through our newspapers we lived each detail of the great catastrophe. We watched the flood and the fire through our television sets. And the horror and sorrow we felt for our stricken city and its people is indescribable.

From my window, I watched the black smoke and the red flames shoot into the sky as the oil storage tanks exploded in the Roanoke district, about a mile and a half from my home. And I smelled the acrid oil smoke that signified destruction of block after block of that district. But I did not venture into those areas because I would have hampered the rescue work.

Still, with all this happening to my city, I had a feeling of personal safety, as did most of my neighbors. "Why?" I kept asking myself. "Why, with all this danger, should I feel safe?" I remembered from history all the millions who had died in floods—unknown thousands during China's Yellow River disaster alone. But still I felt safe. It was something more than being just geographically safe.

I realized that with the great increase in medical knowledge and with today's "wonder drugs," an epidemic was quite unlikely. But my feeling of safety was something more than that. It seemed to stem from the security of just knowing that my personal physician was still in his office, ready to minister to me if I needed him. That was a warm feeling of safety for me, and for my neighbors. I knew my doctor was standing by, ready to assist in the disaster area if needed. But he was still in his office! And that knowledge was like a prop, supporting me and thousands of neighbors, keeping us safe from the surging flood and the raging fires.

But my feeling of personal safety was still broader. I knew what was actually being done to help the people in the stricken areas—and what would be done in case the disaster should somehow spread to my front door.

I kept asking myself many questions. Why were there no serious casualties in the great fire area? Why was there no real health problem? Why did all of us, without question, boil or chlorinate our drinking water, and then stop boiling it when we were told it was no

IN DISASTER

by JOSEPHINE MAY

Sol Studna, Kansas City Star

longer necessary? Why did we obediently go about the arduous task of burying our garbage in our own back yards when we were informed it was hazardous to burn it? Why this implicit confidence? In whom? I was determined to find out.

First of all, I found that public health organization was not ideal. There was no central authority to handle such an emergency. Despite the fact that for some time many groups, including young veterans in the medical profession, had been advocating such an authority, it had not been set up. Plans are still under way for it.

Despite this lack of a central authority, I found that cooperation among the various groups, such as the City Health Department, civil defense, the medical profession, the Red Cross, Army and Navy, and federal, state and county health authorities, was most commendable and heartening. I believe it was their working together, perhaps even their overlapping of duties, that saved Kansas City from even worse havoc.

Out of the office of Dr. Hugh L. Dwyer, public health director, came much of the information for keeping the public informed. For ten days, beginning on that black Friday the thirteenth, the phones in Dr. Dwyer's office were continuously busy. Calls came from people volunteering their services. Many asked about the urgent problem of the city water supply. Word went out that typhoid shots were not urged for the general public, but only for those engaged in the flooded areas. Directions for purifying drinking water were issued. News bulletins for newspapers and radio broadcasts averted undue alarm or panic. Dr. Dwyer and his aides provided outstanding leadership and guidance that led to close cooperation with all other health groups.

The Division of Public Health Engineering, under the leadership of Commissioner C. C. Potter, dealt with many of the vital problems that safeguarded our health. The Federal Food and Drug Administration joined forces with the City Health Department in food and restaurant inspection, food salvage work and other important duties. Aid came, too, from Navy spray crews to control insect infestation. Approximately 15,000,000 free tablets for purifying water were obtained by the U. S. Public Health Service, and distributed to all drug stores by the Pharmaceutical Association aided by the Boy Scouts. Dead animal disposal work was coordinated through the Army Engineers and local rendering companies. Rodent control was the joint effort of the Red Cross, the Public Health Engineers and local exterminating companies. All these units worked together to protect me and all my Kansas City neighbors.

On call during the entire emergency were all members of the Jackson County Medical Society, who, under the leadership of their president, Dr. Frederick B. Campbell, volunteered their services for any need that should arise. Most members of the medical profession contributed their services with- *(Continued on page 62)*

THE GROWING POLIO PROBLEM

POLIO is the one uncontrollable epidemic disease that is on the increase today. From the number of cases reported in recent years it is evident that, despite all our efforts, polio is affecting more people each year than ever before. In the last four years, 1948 through 1951, there have been more cases of polio in the United States—132,000—than in the previous ten years combined.

In the curbing of disease medical science has made brilliant progress. Every day hundreds of children and adults are saved from sickness and death by recently developed drugs, serums, vaccines and antibiotics. Measles can be checked by gamma globulin—a human blood fraction. Pneumonia, tuberculosis and diphtheria are curbed by penicillin, streptomycin and inoculations.

Polio is one of the few major diseases that cannot be prevented or cured by a vaccine, serum, drug or antibiotic. *But there is every indication that this will not always be true.*

In 1938 the National Foundation for Infantile Paralysis was organized by Pres. Franklin D. Roosevelt to lead the fight against polio. Its objective was elimination of polio through scientific research, but the most immediate need was to assure proper treatment for thousands of polio patients, regardless of their race, creed or ability to pay. Making such treatment available to all who needed it entailed a multitude of problems.

For one thing, there was the public's inordinate fear of polio. They knew it as "the Crippler" that flourished during the summer months and, when it reached epidemic proportions, spread panic through entire communities. When it struck in a community, families hastily gathered their children, packed their belongings and fled. The exodus was so great in some places that neighboring communities set up road blocks and armed guards to turn back the panic-stricken. Families of polio victims were shunned by their neighbors as though they carried the plague.

A few doctors and nurses were familiar with the disease, but the number was wholly inadequate to provide essential medical care. An entire corps of medical and hospital personnel required training in diagnosis and treatment. Of paramount importance was the need for hospital facilities in which to care for the stricken.

In 1938 only about 300 general hospitals equipped to care for polio patients would accept them. The reluctance on the part of hospital administrators to admit polio patients to their wards was due largely to public fear. Today, because of a program of public and professional education as well as the provision of essential staff and equipment by the National Foundation, the number of general hospitals accepting polio patients has increased to well over 900.

Thus, the desire to make proper treatment available to polio patients gave birth to real effort to train adequate medical and hospital personnel, as well as a program of education for the general public which would bring understanding without unreasonable fear.

But providing treatment, essential as it was and is, could merely be a stopgap in the fight against polio. The urgent need was to carry out an intense coordinated program of scientific research that ultimately would lead to prevention or control. Therefore, in 1938 the National Foundation for Infantile Paralysis, through its March of Dimes, embarked on a threefold, unified program of (1) financing the cost of proper treatment; (2) education, both lay and professional; and (3) scientific research.

Since the very beginning the American people have joined wholeheartedly in the fight. Not only have they donated millions of dollars to this program; they have also given freely of their services. At the present time, more than 65,000 men and women voluntarily give their time and energies in maintaining the 2938 local chapters of the National Foundation (including those in U. S. territorial possessions) where people can get help in their own communities when polio strikes.

In the last 14 years almost $14,000,000 has been al-

by BASIL O'CONNOR

Not long ago, 10,000 people got polio each year; now the average is 30,000.

located to train doctors, nurses and physical therapists in the diagnosis and treatment of infantile paralysis. Special courses have been initiated throughout the country at recognized institutions. As a result of this program, more than 2900 professional personnel are adequately trained to help whenever and wherever polio may occur.

The National Foundation's program of giving the public the facts has helped the American people realize that they must learn to "live with polio" until it has been finally eradicated. The unreasoning fear and panic of the past are largely gone. In their place has come awareness of the disease and its treatment, a willingness to help its victims and a determination to conquer it. Today, when polio strikes a community, people do not flee their homes. Instead, they volunteer their services to help stricken neighbors.

But despite the number of people informed about polio—and the increasing number of patients who recover either completely or with only slight after-effects from the disease—polio still is completely unpredictable. There was a time when 10,000 or fewer new polio cases a year was considered average. The average now expected, based on records of the previous five years, is about 30,000 new cases annually. And even this cannot be depended on; in 1949 there were over 42,000 cases. There is no way of predicting the area where polio will attack, the number of people it will strike or the number of those who will be seriously crippled or die because of this disease.

Since 1938, over $120,000,000 has been spent by the National Foundation in caring for polio patients. Four of every five persons who get recognized cases of polio receive direct financial help from the March of Dimes.

There is no polio patient who has not been aided some way because of services made possible by the March of Dimes. The National Foundation's program has improved care generally, furnished equipment—"iron lungs," aspirators, hot pack apparatus—for rapid flight to the most remote community; it has trained professional personnel for work in treatment centers and scientific laboratories and helped increase facilities for the care of all polio patients.

During the last four years, marked by increasing numbers of polio cases and rising costs, $79,000,000 has been spent to treat patients. As a result, at the end of each of these years the National Foundation has been in debt for patient care, despite increased contributions from the public each year.

In the midst of these serious epidemics and heavy expenditures, the National Foundation has continued to expand its scientific research programs at a cost of over $14,000,000 from 1938 to September, 1951. The returns are now becoming evident.

Scientists supported by the March of Dimes have found that three types of polio virus are capable of causing the disease in human beings. Although all three viruses produce identical clinical symptoms, infection by one will not protect against subsequent infection by either of the other two.

Scientists have also determined that polio is a widespread disease and that only a relatively few people get the paralytic type. Most people who are infected with the polio virus either show no symptoms at all or display only mild illness. It is estimated that for every recognized case of polio, there are 100 or more cases with symptoms so mild that they go undetected. Blood-sampling surveys supported by the March of Dimes indicate that 85 per cent of the population have been exposed to the polio virus by the time they reach 15 years of age and have developed some degree of resistance to the disease.

Within the last few years, a significant milestone has been reached in polio research. Scientists at the Children's Medical Center in Boston, with the aid of March of Dimes funds, have successfully grown polio virus in test tubes containing non-nervous tissue. This accomplishment has increased the hope that a vaccine can be prepared to effectively prevent the disease. It also will speed up the search for a specific chemical or drug to stop the polio virus by making it possible to carry out a test tube search for such a drug, instead of relying only on expensive and time-consuming animal experimentation.

These scientists have recently discovered that polio virus thus grown in test tubes loses some of its infectivity for its original host. This strengthens the hope that it may be possible to develop a strain of polio virus that will no longer be infective for man and can be used to protect him against the disease.

With the continued support of the American people, man surely will outstrip this disease in the race for possession of the bodies of little children and young adults. Polio is attacking more people than ever before, yes, but the American people are fighting it with their contributions and their services. We need no longer fear a conquest by polio. The polio problem has grown—but the March of Dimes will grow with it.

Mr. O'Connor is president of the National Foundation for Infantile Paralysis.

Working on an oak table, Melvin and his secretary, Mrs. Doll S. Duncan, carefully check the insurance company's important account books.

100 YEAR OLD BUSINESS MAN

Post-Dispatch PICTURES (Black Star)

ALL of us youngsters who begin to grumble at 50 or 60 or 70 may well cheer up a bit at the thought of Sylvester Melvin of Greenfield, Ill., still an active leader of his community as he begins his second century. He is secretary-treasurer of the $5,000,000 Green County Mutual Fire Insurance Co., an office to which he has been re-elected every January since 1900. His neighbors expect this month to be no exception. With his secretary, he conducts the office work of the concern at his home, and he does some of its field work as well. He is a well known stockman, an enthusiastic gardener, a regular church-goer—and almost as regular in his daily rounds of the town square.

Last September the traditional picnic and field day of the Southwestern Illinois Angus Breeders Association was held on the Melvin Angus Farms near Greenfield. And, the Greenfield *Argus* records, a feature of the day was a dryly humorous talk by Melvin, who started his Angus herd 62 years ago. In October he and Mrs. Melvin, who is 93, celebrated their seventy-first wedding anniversary. And on Nov. 29 they—and much of Greene County—observed his hundredth birthday.

Melvin has spent all his life in Greene County except four years at Illinois Wesleyan College, of which he is the oldest living graduate. He had been breeding Angus cattle for ten years when his conviction that farm fire insurance was costing too much led to the organization of the Greene County mutual. In the half-century since then, it has been able to reduce premiums by about one-half. Its office is a room in his home, though the only telephone is in the living quarters.

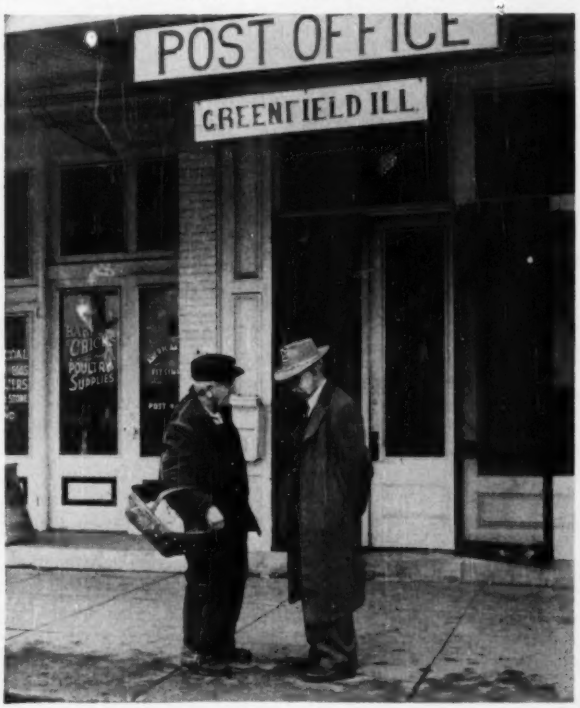
As his community's senior citizen, Melvin is well known by Greenfield's 1000 people. His daily circuit is a leisurely stroll with numerous pauses to chat with friends along the route. It is only when he has taken care of the company's business and his errands are completed that Sylvester Melvin goes home to relax.

When that time comes, he pulls some farm papers from his files and settles down to catch up on his Angus cattle reading—and he does it *without* glasses.

Entering his second century, Melvin still makes an almost daily round of the nearby business section.

Looking over a house on which his company has an insurance application is part of Melvin's field work.

Outside Greenfield's post office, Melvin pauses with an old friend, J. M. Norris, a retired blacksmith.



The day's tasks all completed, Greene County's elder business man leans back to relax in his swivel chair.

SATURDAY AFTERNOON

by DUANE DECKER

CHARLIE SPENCE was sprinkling ashes on the driveway when he heard the back door slam. His son, Steve, came running around the side of the house dressed in sheepskin and toboggan cap. Snowdrifts were piled in rising swirls around the yard and under the light dusting of sand on the street there was a visibly gleaming coat of pure ice.

"Hey, Dad—don't forget," Steve yelled, slowing down a little. "You're coming up to the chute with us. You promised that you would for sure this time, remember."

"I remember," Charlie Spence said, and he certainly did. Lying awake half the night before, he'd thought of nothing else, trying to steel himself against a dread and fear that he could not hope to explain—not to a 12 year old boy who took, in well adjusted stride, what he shamefully shrank from.

"Boy, that chute will be the fastest ever today," Steve said, gleefully. "I'm going up to Tommy Marshall's now,

to get him and his father. He said they'd bring their big toboggan so we can all ride together. Then we'll pick you up."

"How soon, Son?"

"Two shakes," Steve said and Charlie watched him scurry down the street while he tried to shut off all the easy, last-minute excuses that, by this time, came automatically to mind. But this time, finally, he couldn't crawl out of it. Too late for that now.

All through the winter it had been so simple for him to avoid this issue when it came up—and it came up almost every Saturday afternoon that snow covered the ground. He'd told Steve that he had a headache, or a dentist's appointment, or some letters to write. It had started to puzzle Steve, he knew, because Saturday afternoon had always been the time they'd done things together. Until this winter, after the municipal toboggan chute had been built.

It was a sickening sort of fear that had been with him ever since that time during the war when the transport plane went out of control somewhere over the Philippines. It had looked like the end until—miraculously—the pilot somehow regained control just as they were running out of altitude. Nothing at all had happened, actually. They'd landed safe and sound and there wasn't even a good G.I. story to bring home to Steve. But those had been a few brief minutes he'd never been able to get out of his mind. After that, he'd never boarded a transport without his St. Christopher medal.

Instead of trying to knock the fear out of himself, since the war, he'd simply avoided the high places and the sudden, plunging descent. He'd consoled himself that it was just a minor quirk of no importance. Which it had been, until the municipal chute came along. Now it was a major issue. For it had by now—thanks to his sorry string of excuses and alibis—reached the point where his own son's respect hinged upon it.

He'd realized that, with a shock, just the night before. Steve had been telling him, before dinner, about a new kid on the block. This new kid, Steve said scornfully, had walked up the hill with him reluctantly, looking paler with every step. The new kid had climbed into the toboggan, taken one look down the frozen runway and jumped out. "White as a sheet!" Steve said, contemptuously. "Scared as a rabbit—and he's *two whole years* older than I am!"

Suddenly Charlie Spence had been aware of a warmth in his face and had known that he was flushing, guilty. Steve saw it in one quick, penetrating, small-boy glance.

This was the way for father and son to spend it—but would that war-born dread cost him the respect of his boy?

The seed of suspicion was planted in his mind in that moment. And Charlie Spence had known he had to act quickly.

"Steve," he said, quietly, "I'd like to ride that chute with you tomorrow."

"Honest?" Steve cried. "No kidding? Oh boy, swell!"

So that settled it. Or rather, one ride down the chute would settle it.

He spread the last of the ashes on the driveway and went inside to get warmly dressed. But before he started to change, he hunted through all his dresser until he found the thing he hadn't worn since his last plane ride—the St. Christopher. That was how he felt about this toboggan ride.

As he came downstairs, he saw, through the front window, the procession coming up the street: Steve, Tommy Marshall and big Jim Marshall, who was pulling a long toboggan. When he went outside to meet them, he was aware of the pleased look on Steve's face. Jim Marshall said, "Well, well, Charlie. About time you joined us in our Saturday afternoon fun."

"I know," Charlie told him. "But one thing or another seemed to keep cropping up."

"That freeze in the night fixed things," said Jim. "They've figured out somehow that when it's iced this way, a loaded toboggan hits 80 miles an hour at the bottom."

"That's travelling," Charlie Spence said.

The chute was near the long and steep fourteenth hole of the municipal golf course—a stoutly constructed plank affair, itself hardly wider than a toboggan. Charlie Spence, watching as they approached, saw one fly down the track, a shooting blur that suddenly flattened into a toboggan as it hit the bottom and skimmed like a gull across the level field.

They pressed their way up the steep hill. Charlie found himself constantly pushing a little ahead of the others. Jim Marshall grinned and said, "Took you all winter to get out here, so I guess you're trying to make up for lost time."

Charlie nodded and forced a grin, too. But he knew that what urged him on wasn't eagerness; it was guilt because of his fear, and an urge to get it over with before he lost this small pinch of nerve.

From the peak of the hill the chute looked sickeningly steep and long. And as they got in line to wait their turn, he noticed how instantly a descending toboggan picked up speed, then screamed down like a mammoth bullet shot from an oversize gun.

It seemed an endless wait until their turn. Finally they stepped forward and Jim Marshall lined up the toboggan.

"Charlie, you ride front," he said. "You get the biggest belt up there and we've all done it often."

Charlie nodded, his throat too dry for words to come out. He stepped inside and sat down, pulling his legs up as he had seen others do. Then, as they climbed in behind him, some perverse force inside him made him do what he had planned never to do: he looked straight down the chute.

He felt suddenly dizzy. *(Continued on page 60)*

they won't say die

by ALTON L. BLAKESLEE

THE restaurant drummed with the familiar hubbub of noonday voices. Voices gay, serious, shrill, deep, always creating the same pulsing babble though they roll over any of hundreds of different topics. Some topics you quickly forget, others you remember . . .

At my table the subject was one you couldn't forget. It is a disease, little known, neglected, relentless. Three young men were telling their stories about it. Henry and Frank may die of it. And Jess has a 5 year old son who is certainly doomed to die in five to ten years unless science finds some way of controlling it.

The disease is muscular dystrophy, which makes muscles waste away. It cripples by making muscles flabby and useless. It can cripple further when unaffected muscles pull the wrong way, twisting limbs and freezing them in painful posture.

It doesn't kill by itself, but the outlook has always been death for young children and often for adults. For the muscle destruction spreads and may finally go so far that a person cannot fight off infectious diseases. Breathing muscles often become affected and he is unable to cough to clear his throat and lungs when pneumonia or other diseases strike. A simple cold can become a terrifying thing.

The cause is unknown. It is not contagious. No effective treatment is known. The outlook seems hopeless. But these three young men aren't quitting. They and hundreds of other men and women, mostly parents of sick youngsters, have declared war on "MD"—muscular dystrophy—and are looking to the future with hope.

"At least 100,000 Americans have muscular dystrophy, yet almost nothing is being done about it," Jess said. "More than half the victims are children. But few people have ever heard of MD. Many doctors know little about it. We think something can and should and must be done, especially in research to try to find the cause and to develop treatments. That's why we started the Muscular Dystrophy Association. Our first goal is to get money for research."

As one of his own contributions, Jess made a movie showing what MD does to children, how gradually it saps their strength, confines them to wheelchairs, then to bed.

"We first noticed something wrong with our boy about two years ago," Jess said. "The doctor told us it probably was flat feet. Flat feet! That's often the first diagnosis, or rather the mis-diagnosis, because the disease is so subtle at the start. It wasn't until later on, that we got the verdict of MD when a doctor made a muscle biopsy.

"Jay can't balance himself very well. At the least thing, he falls over. He can't run, and now he can't even step up a step. We bought him a cowboy suit because he wanted to be like the other kids. But he can't play with them. He's always falling down and too often he cuts his head when he does.

"Our younger girl is okay. But MD is often inherited, with the susceptibility passing through the mother and affecting boys mostly. So maybe her kids will get it, if she has boys. The only hope for saving Jay, and the girl's children, is medical research."

There are three main types of muscular dystrophy. One begins early in childhood, from the ages of 3 to nearly 10. It progresses rapidly, involving more and more muscles, and few children live beyond adolescence. It is the most prevalent form, and the kind that little Jay has. The affected muscles, especially the calves, grow larger, from deposits of fat. Tragically, children touched by this disease sometimes win healthy baby contests because their legs look so plump and strong. Actually the legs are weak, and grow weaker.

The story of "MD," wasting disease of the muscles, and the valiant patients who may yet defeat it

The muscles degenerate, and become shortened so these children walk on their toes. They may waddle from side to side, be unable to rise from the floor or a chair. Often they get moon faces, from fat deposits in the sick muscles. The disease is three times more common in boys than girls.

A second main type begins in childhood or adolescence, often starting in the shoulder girdle muscles, the upper arms, thighs and back. It goes more slowly, so patients live to middle age. Hereditary, this form affects boys and girls about equally.

The third form begins in early adulthood, in the face muscles or well up on the shoulder girdle and upper arms. It makes lips taper outward and the lower lip curve downward. Lip muscles are affected so people can't whistle or drink through straws.

There are other, rarer types of muscular dystrophy, including a form which begins *(Continued on page 63)*

Mary's whining was not but a sign of a

The doctor's check-up and his prompt treatment

WE seldom think of a child suffering from a heart condition. Yet rheumatic fever frequently leaves its victims with permanent heart damage.

Warning signs to watch for in children are general lassitude, vague stomach-aches, or other discomforts that parents are apt to shrug off as "growing pains." There is something wrong if a child tires too easily, if a child is on edge, whining and complaining frequently without provocation.

Behavior changes or complaints like these could be signs of rheumatic fever. No parent can afford to ignore such warnings. Only your doctor can accurately diagnose such symptoms. He can tell you, after a brief examination, whether your child is suffering from rheumatic fever or some other disorder.

Beware of well-meaning advice

Neighbors are always sympathetic when illness strikes, and they often try to help by recommending a remedy. Never follow such well-meaning but often dangerous suggestions. When your child has persistent signs of illness, see your doctor—it will cost you less in the long run.

Recent discoveries and developments in hormone drug therapy have given today's physician a completely new outlook on the treatment of rheumatic fever. For example, doctors have found that the use of these new hormones in treating

Physiologic Therapeutics Through Bioresearch For Longer Useful Living

serious illness

found the cause

prevented permanent damage

children often results in remarkable over-all relief, if used in time. Today, many children who have been treated by a physician are leading normal lives free of pain.

Guard your family

If something seems to be wrong, make an appointment today to take your child to the doctor. Let him look the child over, make simple tests, if necessary, tell you what to do to keep your child healthy. He can quickly put your mind at ease, IF you let him. Nothing is more valuable than good health—and keeping it is a responsibility you owe to yourself and every member of your family.

Let the doctor decide

Today, all of medicine's amazing recent discoveries in diagnostic procedures, treatment and new drugs are at your doctor's command.

The Armour Laboratories is proud of its share in the development of many of these drugs. ACTHAR (A. C. T. H.-Armour), one of the most effective of these new hormone drugs, represents the results of many years of research by Armour scientists collaborating with leading investigators in the field of medicine. ACTHAR is available to you through your doctor. He may, or may not, find you need it. But you'll feel better, stay better, if you let him decide. See your doctor regularly.

The Armour Laboratories

Sole producer of ACTHAR (A. C. T. H.—Armour). Since 1885, pioneer manufacturer of sutures and pharmaceuticals prescribed by the medical profession—notably THYROID, INSULIN, LIVER PREPARATIONS, and PITUITARY HORMONE PRODUCTS.

HOW TO EAT A POTATO *and why*

The potato's supply of vitamin C is a big weapon in our war on scurvy, but sabotage in the kitchen can put it out of commission.

FOOD and HEALTH

by
ANNA MAY WILSON

"RAW potatoes," said my father, "that's what saved those sourdoughs' lives. Why, when the miners were dying of scurvy, alone in their cabins in the frozen North, a bag of ordinary, everyday, raw Irish potatoes was worth more to them than all the gold dust in Alaska!" And so he started a favorite tale.

My childhood was sprinkled thick with the gold dust of Dad's adventures in the land of the midnight sun. He gave travelogues on the subject, and I was never happier than when I could sit in a darkened hall and watch my very own father, the footlights shining on his black curly hair and his blue, blue eyes shining down on me as he told his tales of the gold rush days in the Far North.

Best of all I liked this tale of how a medical mission set out to save miners from the sure death of scurvy brought on by their diet of salt pork, navy beans, sourdough bread and black coffee.

Driving a dog sled laden with supplies, the rescuers would spot a smokeless cabin chimney. This was always a sign that help was needed, for no man deliberately lived without fire in that cold land. They would break open the door and usually find the victim of the scourge curled up on his bunk waiting for the end. After emergency measures, raw potatoes were the treatment and raw potatoes were the cure.

The story always thrilled me. Until lately it never occurred to me to question its accuracy. Can potatoes prevent scurvy? I asked this question of one of America's foremost medical nutritionists.

"Yes," was his answer, "potatoes are one of our cheap sources of vitamin C and without them scurvy would certainly be more common in the world today. Even in the small quantity usual in the American diet, potatoes are not insignificant as a protective food if they are properly cooked."

"How about eating them raw?" I asked. "You know the old wives' tale about raw potatoes turning your blood to water."

"You are right in labeling it an old wives' tale. It is nothing more, but please don't *recommend* eating raw potatoes. The starch of raw potato is not easily digested. In spite of the theories of the back-to-nature boys, potatoes are one of the many foods that are more readily digested when cooked."

How *are* potatoes properly cooked?

Ah, that is a bit of household science. We must cook them long enough to rupture the hard-to-digest cellulose envelopes that surround the starch granules and yet not long enough to destroy much of the food value. Most important, we must cook them in such a way that they will taste good as well as be good. What's more, we must do all three things at once. (That's nothing—housewives always do at least three things at once.)

If a potato is "just so much starch," as I have often heard people say, then breaking down those cellulose envelopes that imprison the starch would solve our problem. Let us look at a potato and see what other desirable nutrients it has to offer.

One medium potato, if properly cooked, can give us not only 118 calories of food energy but as much calcium as one and a half tablespoons of cream cheese; as much phosphorus as a thick slice of whole-wheat bread; almost as much iron as two frankfurters; as much of the B vitamins, thiamin and niacin, as a cup of oyster stew; as much protein as a half cup of beef soup (not much); and as much vitamin C as a small tangerine! And that, dear readers, is what some people have been calling "just so much starch."

The above mentioned bundle of nutrients (one medium potato) was, you will remember, a *properly cooked* potato. Now let us see what happens when a cute little potato saboteur goes to work on it.

Her name is Elsie, she is young (or old), she just *loves* homemaking and she is very, very practical. She always cooks up enough potatoes to last for several days (you know, with modern refrigeration and all). Yes, she

peels them. (How else could she be sure to get out all the spots?) She covers them with plenty of water so they won't burn while she is upstairs making the beds. But she carefully drains them and lets them cool before putting them in the refrigerator.

Why, even two days later they are simply delicious when hash browned for John's supper. Now, do you know what this little villain has done? She has done her best to make John's potatoes just so much starch.

When she peeled the potatoes she robbed them of their best defense against loss of vitamins and minerals while cooking. In a study made by the Bureau of Human Nutrition and Home Economics it was found that potatoes boiled whole in their skins can retain practically all of their vitamin C, thiamin, nicotinic acid and minerals.

When Elsie covered the potatoes with lots of water she was reducing their vitamin C value by at least 10 per cent. And then when she threw the water down the drain she was making sure that any other nutrients dissolved in it would never be used by man.

Elsie's "efficiency" in cooking the potatoes ahead of time is perhaps her worst offense. During the storage in the refrigerator their vitamin C content took a nose dive. And then, when she chopped them up in nice little cubes (early in the afternoon, of course) and browned them—well, her job was complete. Only about one-fourth of the vitamin C John could have had for supper was left in the depleted potatoes.

Now, I'd like to tell you all about how helpful Annie rushes home at the last moment and turns out the perfect meal. But I'm getting pretty tired, aren't you? Let's summarize.

1. Potatoes boiled whole in their skins retain practically all of their vitamin C and a high degree of the other nutrients present. Paring before boiling decreases several of those values as much as 30 per cent. Some nutrients are in the cooking water, so use it when possible.

2. The volume of cooking water also affects the value of protective foods retained in a boiled potato. Use the smallest amount of water

(*Continued on page 42*)

FAMILY FRIEND FOR LIFE!

A GOOD DRINK to *start* on—a good drink to *stay* on—POSTUM is enjoyed by young and old alike . . . truly your family's *friend for life!*

Youngsters like POSTUM's hearty, grain-rich flavor—and it contains nothing that could possibly harm them—no drugs, no stimulants. POSTUM is *your* health's best friend, too—it can never, never cause you sleepless nights, nervousness or indigestion, due to the ill-effects of caffein. For POSTUM is *caffein-free!* So, enjoy POSTUM *regularly*—let the whole family enjoy it—and see how it helps make *being* together, doing things together more fun!

Here are the scientific facts about caffein in coffee and tea! Caffein is a drug! It is a stimulant that acts on the brain and central nervous system. Also, in susceptible persons, caffein tends to produce harmful stomach acidity. So, while many people can drink coffee or tea without ill-effect, for others indigestion, nervous hypertension and sleepless nights result.*

**See "Caffein and Peptic Ulcer" by Drs. J. A. Roth, A. C. Ivy and A. J. Atkinson — A. M. A. Journal, November 25, 1944.*

DOCTORS AGREE: Never give a child coffee. Serve Postum-with-milk instead. Children really love it!

CONTAINS NO CAFFEIN — NO STIMULANTS OF ANY KIND!

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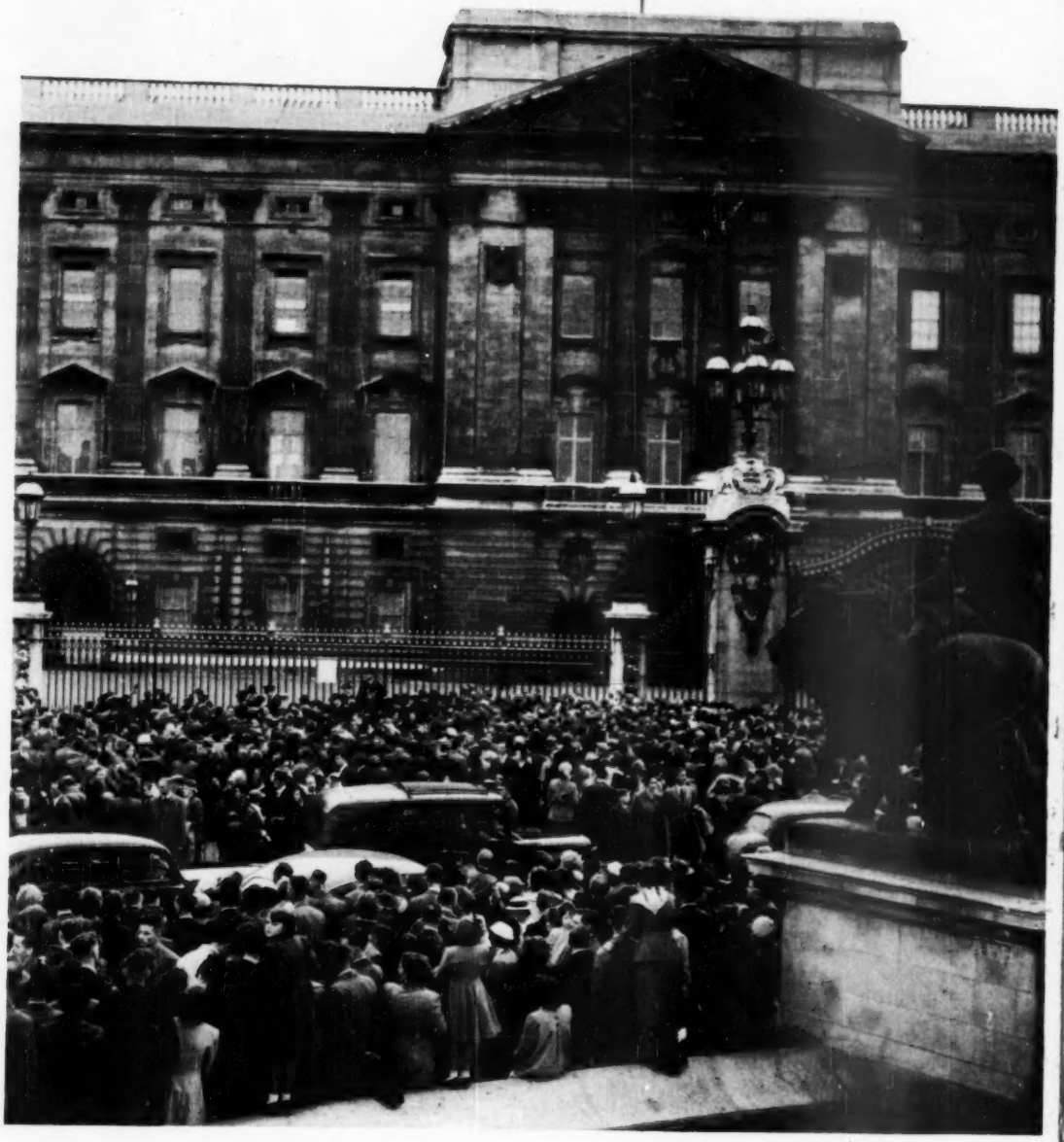

KING'S OPERATION

A surgeon's emergency decision 18 years ago blazed the way for the English monarch's lung resection a few months ago.

WHEN King George VI underwent his recent operation, attending surgeons drew on the knowledge and techniques of an American physician, Dr. Evarts A. Graham of St. Louis, who was the first doctor to remove a patient's lung successfully. That was performed during the year 1933. Today a lung resection is considered an ordinary operation in hospitals all over the world.

In bulletins issued during the King's illness, the attending physicians did not mention the word cancer. They simply stated that the 55 year old monarch (who was 56 last month) "underwent an operation for lung resection." Such an operation is usually performed for cancer, but it is also done in cases involving a cyst, tuberculosis, or bronchiectasis, a condition in which the bronchial tubes carrying air to and from the lung are weakened.

The English doctors' speedy decision to operate and their terse bulletins, worded with the greatest caution, carried the impact of grave trouble. An operation for lung resection means the removal of either the entire lung or the upper or lower lobe.

A patient who has this operation in the early stages of lung cancer has twice as much chance of complete recovery as a patient operated on for stomach cancer. He has a good chance for complete cure, and mortality from the operation itself has been reduced to 5 per cent.

But this has not always been the case. The picture is quite different today because great advances have been made in lung surgery. Had the King suffered his malady only two decades ago the situation would have been considered practically hopeless.

Most important, the new skills and techniques in this type of surgery have, like all other medical research, been passed on from doctor to doctor wherever medicine is practiced. Everywhere medical science works on a communal basis; the findings of one wôrker are freely published for the information of all, and each discovery is but a capstone placed on the previous contributions of scores and possibly hundreds of other workers representing many nations and many races.

Very little is accomplished in medicine by merely searching for a desired result. After the result is attained, as it was in lung resection, it must be tested by search, research and repeated research. This sifting and resifting of results is fundamental to the scientific method in medicine.

This method and its results and this sort of teamwork, motivated by the scientist's desire to discover truth and conquer disease, made it possible for the King to undergo such a serious and delicate operation with more than a moderate degree of success.

What the King's surgeons did in the temporary operating room in Buckingham Palace actually had its beginning in a tense moment at Barnes Hospital in St. Louis on April 5, 1933. Dr. Graham was operating on a 48 year old physician, who had a chronic cough and fever. Careful diagnosis, with the aid of x-rays, had revealed cancer of the upper lobe of the left lung. It was already known that treatment with x-rays and radium was not effective. Dr. Graham and other physicians had only one choice left—surgical treatment.

When Dr. Graham, professor of surgery at Washington School of Medicine and surgeon-in-chief at Barnes Hospital, started to operate, he planned to remove only one lobe. After entering through the back and viewing the diseased lung, he was surprised to find that the cancer had extended from the upper lobe into the bronchus (air tube) of the lower lobe. In order to eradicate the cancer, the entire lung would have to be removed.

"It occurred to me at once," Dr. Graham said later in writing about his experience, "that the only kind of an operation that might offer a chance of cure would be the total removal of the left lung. The patient had brought with him a physician friend who was in the operating room gallery during the operation. I told him it would be useless to remove only one lobe, and I strongly advised removal of the lung. I asked his opinion, but he was not very helpful. He asked if

Worried Londoners gather outside the gates of Buckingham Palace to get news of the King's condition.
British Information Services photo

by JOHN L. BACH

such an operation had been done before. I replied, 'No.' I pointed out that the operation had been successful in animals; in fact, I had done it myself in animals, but that I knew of no case in the human being of a successful one-stage removal of the lung. After a little more discussion, and particularly because I was certain that the patient would want me to take any chances that might effect a cure, I decided to go ahead with the total pneumonectomy or removal of the whole lung."

One vital problem during such an operation is to keep the patient breathing continuously. The situation is somewhat like mending a busy street while keeping the traffic moving. What worried Dr. Graham most of all, however, was whether the middle-aged patient could tolerate the sudden blocking of the pulmonary artery, the main artery from the heart. But no complications arose from the arterial blockage necessary for the operation. Carefully the affected lung was removed.

"I was horrified," Dr. Graham wrote long afterward, "to see the enormous space left after the removal of the lung, and it seemed necessary to me to diminish the size of the space by the removal of ribs. Accordingly, I removed seven ribs, from the fourth to the tenth inclusive."

The operation isn't nearly as radical today. The techniques have been improved greatly since that first operation in St. Louis.

Dr. Graham's patient left the hospital in about two and a half months. He recovered completely. Today, nearly 19 years after that epoch-making operation, he is still practicing medicine in an Eastern city.

Dr. Graham recalls with a smile an interesting anecdote that illustrates the great faith of human beings. When the decision was made to operate, the doctor-patient asked to go home for a few days. This he did and was back at the hospital on the appointed day. After his recovery, he said to Dr. Graham, "I guess you wonder why I wanted to go home before you operated on me. I'll tell you the reason: it wasn't to make my will; I had several fillings in my teeth that needed replacing and I wanted to have it done before the surgery."

In Washington recently a case was reported that involved complete removal of a lung in a 78 year old woman, who recovered completely. Another case was that of a 48 year old farmer who had suffered from pneumonia for six months before he developed a chronic cough and began to lose weight. X-rays helped in the diagnosis of cancer in its early stages. A total pneumonectomy was performed. Three weeks later he was completely recovered. A 67 year old plumber had symptoms for a year which turned out to be caused by cancer in a region of the lung. One whole lung was removed and the patient was discharged from the hospital on the twentieth day as compared with the long convalescence of Dr. Graham's first patient.

There are many medical authorities who believe that cancer of the lung has been increasing at a startling rate in the past few years. Dr. William L. Watson of New York wrote in one of the latest medical journals: "The time has arrived when we should not mince words with the public because the facts seem to indicate clearly that cancer of the lung is a much more common disease today than it was 25 years ago."

Numerous possible explanations are offered for the increased incidence of this disease. First of all, the public and the medical profession are increasingly aware of cancer in general. Improved methods of diagnosis through mass x-ray studies, extension of hospitalization, easily available bronchoscopic examination and routine bronchial studies, all may be factors in the rapid increase in the number of patients suffering from cancer of the lung.

The new antibiotic drugs have led, indirectly, to an increase in the diagnosis of this disease. Prior to penicillin, for example, patients who may have had early cancer of the lungs developed pneumonia. Death often followed. In effect, cancer of the lungs in such patients was masked by the more urgent, sudden pneumonia. With the widespread use of antibiotics, patients are now saved from pneumonia. When they recover they are found to suffer also from cancer of the lungs. Thus though they are not direct diagnostic aids, the antibiotic drugs are a factor in discovering more cases of lung cancer.

The outlook, however, for patients with lung cancer is brighter today than ever before. Early diagnosis, as in all other types of cancer, is necessary for effective treatment. The fact that the King's health was watched so closely by a staff of doctors was greatly in his favor because, in all probability, the diagnosis was made early enough to assure successful surgery.

How to Eat a Potato and Why

(*Continued from page 39*)

possible. Never use more than enough to cover the potatoes and have it boiling when the potatoes are added.

3. Salting potatoes while they are cooking does no great harm.

4. Holding boiled potatoes overnight in the refrigerator is quite destructive to their usefulness as a protective food.

5. Cooking (but not overcooking) potatoes in a pressure saucepan results in good retention of nutrients.

6. Mashed potatoes are all right when made from those freshly boiled whole in their skins, but mashing entails some losses. Mash them just before time to eat (none of this early bird stuff).

7. Baking potatoes whole in their skins is, in general, a good method of conserving nutrients but not as good nutritionally as boiling them whole in their skins.

8. Hash browning of pre-boiled potatoes results in marked loss of both vitamin C and thiamine.

9. Potatoes fried raw, retain about 60 per cent of their vitamin C but lose heavily in thiamine.

10. One good serving of properly cooked Irish potatoes can furnish a third of the recommended daily allowance for vitamin C, and at a comfortable price.

11. The way to eat a potato is to do it just as soon as possible after it's cooked.

The moral in this story is: "Don't cook your potatoes day before yesterday."

Diet, Body Weight and Hardening of the Arteries

Although the cause of hardening of the arteries (arteriosclerosis) is not known, no longer is the disease regarded merely as an inevitable consequence of advancing age about which little or nothing can be done. Rather, present knowledge indicates that the disease may be a fault in the metabolism of fats and other lipids. Furthermore, recent advances in the dietary and medicinal treatment of this progressive disease may now make possible the retarding of its progress.

A recent four year clinical study indicates that persons with arteriosclerosis may be distinctly benefited by a high protein, low fat diet adequate in vitamins and minerals. This diet provides no more calories than needed for maintaining the individual at ideal weight or for effecting required weight reduction in the obese and those much over ideal weight. Lean meats at noon and evening meals are among the protein foods used for assuring adequate intake of biologically complete protein. In the studies, the high protein, low fat diet produced an increase in well-being and in capacity for work.

Since arteriosclerosis is always a threat in advancing years, modern preventive medicine stresses the importance of maintaining normal body weight. Obesity or weight much above the normal is believed to predispose the individual to development of the disease and to aggravate the arteriosclerotic process. A good diet for the person with arteriosclerosis is one which provides optimal nutrition and which is built around meat, milk, eggs, vegetables, cereals, and fruit but furnishing no more food energy than required for maintaining normal weight. In treatment of the disease, the physician may prescribe food restrictions for reducing weight and for limiting the intake of fat and lipids and such medication as he considers indicated.

In disease as well as in health, meat offers a practical means for importantly contributing to the adequacy of the diet. Meat richly provides the kind of protein needed for the upkeep and growth of all tissues of the body, for their normal functioning, and for maintaining general resistance to infection. Meat is also an important source of iron and of the B complex vitamins, niacin, pyridoxine, riboflavin, thiamine, and the newly discovered vitamin B_{12}.

The Seal of Acceptance denotes that the nutritional statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.

American Meat Institute
Main Office, Chicago...Members Throughout the United States

PREVIEW

by JANET FORRESTER WELSH

IN THIS modern day and age when everyone is enlightened on every phase of reproduction, from fertilization to the first labor contraction, it is surprising how many young mothers approach the birth of their babies without a glimmer of light on what will happen to them once they reach the hospital. Their busy doctors haven't had time to explain, and bridge table acquaintances have only gone into the blood-curdling aspects of "the hardest time my doctor ever saw," leaving the uninitiated mother with forebodings about her "ordeal" to come.

It is recognized that a woman can make her labor longer and harder by being tense and frightened. The only way to avoid the feeling of panic that accompanies a new and untried experience is to learn in advance exactly what to expect.

I didn't know exactly what happens from beginning to end either, until I'd had my fourth baby. I had her by the natural childbirth method, without anesthetic, and had the privilege of learning about the wonderful phenomenon of birth by watching my own baby come into the world.

On Friday night I was alone in the house when my membrane ruptured and I knew the time had come. My husband had gone to do a little shopping for me and I excitedly awaited his return. As I waited my happy excitement grew and I had to share it with someone, so I called a few close friends to tell them I would soon be on my way to the hospital. At the end of this recital I called my doctor and told him that I was coming in as soon as my husband returned. He said he would be right there. He knew how badly I wanted to see my baby born and would do everything he could to help me succeed.

When my husband came back half an hour later I greeted him with, "Honey, are you ready to take me to the hospital?" His eyes opened wide and he said, "Are you ready to go?" It was two weeks before the expected date and I was overjoyed that the waiting was at an end.

We piled into the car with my overnight bag, and my husband drove carefully to avoid bumps in the road. At the hospital we went directly to the admitting office.

OF BIRTH

Here's what happens from the time Mother enters the hospital till her baby arrives.

This was routine for us. While my husband gave the pertinent data and had me admitted, a nurse was summoned to escort me to the maternity ward.

I was ushered into the labor room and asked to undress and put on a hospital johnny coat and then climb in bed. Soon the nurse returned with an information blank and I gave my name, age, previous children and so on. She disappeared with the blank and came back with the "prepping tray." I was shaved so that there would be no hiding place for germs. Next, an enema to clean me out, and my "prepping" was complete. She gave me a vitamin K injection then, to help my blood do a better job of clotting, and I was ready for my doctor to examine me.

He came over to my side and said, "Well, how is it going?"

"I'm here," I stated, "But I'm not doing anything yet."

He nodded, slipping on his stethoscope, and bent over to listen to the baby's heartbeat. He checked my blood pressure and then with a gloved hand he examined me rectally to see how much my cervix had dilated and how low the baby's head was. As he slipped off the rubber glove he said, "Your labor hasn't begun and you might as well get a good night's sleep in your room. Sometimes it takes several hours for labor to begin after the membrane ruptures. I'll see you in the morning if you don't start before."

When I went into my room I found a sleepy husband waiting for word. I told him what the doctor had said and told him to go home. I could call him when I needed him.

Nothing had happened by noon the next day and the doctor said, "I want you to take a nap after lunch. You want to be well rested when you start. I expect you will wake up in labor."

At 2:30 I opened an eye. I thought I detected a twinge. In a moment I was wide awake and was having a nice contraction. I rang for the nurse and asked if I might have a telephone. When it came I called my husband and said, "I'm in labor now. Come over right away because I want you to be with me as long as possible."

In what seemed like no time at all he appeared at the door with an anxious question written all over his face.

"Come on in and relax, dear," I said. "I've only begun and you can time my contractions for me."

It was good to have him there and I relaxed happily with each contraction, I knew I would have quite a while to wait before I had to go back to the labor room. The first stage of labor, in which the cervix (mouth of the uterus) opens to admit passage of the baby, consumes most of the actual labor time. It opens slowly and cannot be hurried.

An intern came in to see how I was progressing so that he could call my doctor as soon as he was needed. He wanted to know if I was ready to go to the labor room.

"No," I said, "If you don't mind, I'd rather be with my husband and he isn't allowed in the labor room. I think I have a couple of hours yet before I will need to go. I'll call if I need you sooner."

I was progressing nicely and my contractions were becoming good and strong. Deep abdominal breathing is another principle of natural childbirth and I began to experiment with it. I found that puffing my abdomen out as far as it would go lessened the discomfort. The feeling was simply discomfort and not pain. With the other babies, I had been given demerol injections at this point. I didn't need it this time.

About 5:30 I was becoming more uncomfortable and I asked my husband to press upward on the small of my back. Again the discomfort lessened. When the intern reappeared, I was relaxing with difficulty and was ready to go to the labor room. I was distinctly uncomfortable but there was nothing about it that could be called suffering by any stretch of the imagination. In the labor room the contractions began coming every two minutes and were increasing in intensity. The intern examined me carefully and went to call my doctor.

Very shortly the half dozen or dozen real pains began which heralded the approach of second-stage labor. Those were the only real pains and they were corkers. But since I knew there would be only a few, I could easily put up with them in order to see my baby born.

I heard my doctor's voice in the hall and in a moment, along with a whopping good pain, I felt another sensation. A moment later the new sensation came again, but this time there was no pain. It was a good, bearing down feeling and I realized that the second stage had begun. The second stage is the descension and actual birth of the baby and is much more rapid than the first stage, especially in women who have had more than one child.

I had never before reached (*Continued on page 60*)

BEAUTY and health

COSMETIC ADVERTISING is *your* business

by VERONICA LUCEY CONLEY

You and your neighbors can improve the ads by buying only those products sold under reasonable claims.

NO ASPECT of the cosmetic industry is as severely criticized by the public as its advertising. But few of us realize that an industry's approach to advertising invariably reflects what its executives believe the public wants. How do they find out what the public wants? By watching the effect on profits of various ads.

That is why you and I are the real bosses of the cosmetic industry and its advertising. We don't have to buy cosmetics promoted with promises beyond what they can accomplish. We can encourage manufacturers who keep product and advertising quality high.

The most serious offender is the manufacturer whose prime aim in entering the cosmetic industry is to make a lot of money in a hurry. He is unconcerned about his methods so long as they bring quick profits. The safety, quality and usefulness of the product are unimportant to him. He may resort to false and misleading claims. If he works fast enough he may escape action by the authorities, since it takes time for government agencies to get into motion. Whether or not he is successful, his methods are associated in the minds of the public with the cosmetic industry as a whole. As a result, he is as unpopular with reputable manufacturers as he is with government officials and the public who were disappointed by his goods. Fortunately, it is becoming less and less common for such tactics to achieve financial rewards worth the risk. The credit goes largely to the growing awareness of a public becoming daily more alert to demand proof for unlikely promises.

Advertising agencies sense this trend and are increasingly wary of making claims that might boomerang. In a talk before a group of cosmetic chemists, an advertising executive cited an incident from the autobiography of P. T. Barnum. During the early 1860s, Barnum promoted what was called his "American Museum." It was replete with animal freaks of all kinds. Barnum himself supplemented nature's handiwork whenever he felt it necessary, with the result that he had quite a collection of eye-popping wonders. It was not strange that he had a problem to get customers out of his museum to make room for new ones. So, at the last of his exhibits, instead of "This Way Out," his sign read "To the Egress." Thinking that this was some rare bird, the customers piled through the door and found themselves out on the street.

This happened almost 100 years ago. Do we parallel it in our advertising today? Let's look at a few claims that appeared in a recent Sunday newspaper.

A caption on an ad for soapless shampoo says that soaping dulls the hair. This claim probably arises from the fact that soap constituents unite with calcium and magnesium in hard water to form an insoluble precipitate. If considerable amounts of these salts remain on the hair, a noticeable lack of sheen will result. The use of a vinegar or lemon rinse offsets this action. Synthetic detergents do not react this way. This advertisement would be more nearly ideal, however, if the many fine properties of synthetic detergent shampoos were emphasized rather than the negative aspects of a competitive product—in this case, soap shampoos.

An ad for a hand cream says it contains lanolin—for dry skin. This claim also appears frequently in conjunction with soaps, face creams, lotions, shampoos and other cosmetics. Lanolin or wool fat is chemically similar to skin fats and is effective in temporarily substituting for them when the skin is deficient. The question may arise immediately as to why, if lanolin is so effective, it is not used uncombined. Pure lanolin is a sticky, rather malodorous yellow-brown fat. It lacks esthetic properties so essential in cosmetics. Even in small amounts in a cream, lanolin is detectable because its color and odor are difficult to disguise.

Lanolin's effectiveness for emollient purposes in soaps and shampoos is questionable. The mechanical process of washing and rinsing quite thoroughly removes dirt and other substances from the skin surface. How then is sufficient lanolin left on the skin to soften it? Furthermore, the amount of lanolin in detergents must be limited, since lanolin tends to reduce lathering. Nevertheless, some physicians, apparently from their clinical experience, think there is merit in soaps superfatted with lanolin for dry skin.

A product called a fingernail cosmetic would, according to another ad, strengthen, cleanse and prevent age growth of the nails if applied each night over nail polish. These claims are contrary to scientific knowledge. The first obvious question is how can a substance applied over nail polish even reach the nail surface to have any effect whatsoever. A coat of nail lacquer provides a resistant coating over the nail that can be penetrated only by solvents such as those in polish removers.

Nail growth and intrinsic strength are determined by internal factors, and no preparation applied to the surface can increase either of them.

The claim that women over 35 can look younger is sure-fire. In this case it refers to a hormone cream. The cream is claimed to contain the usual 10,000 International Units of natural estrogenic hormone per ounce. Among other things, it is claimed that "these natural estrogens enable the supporting undertissues of your skin to retain moisture" and that "it is this moisture which gives your skin the full firm look that is the secret of a young woman's beauty." The aging process that leads to wrinkles and relaxed contours involves a great many factors. The role of moisture in these skin changes is not well understood. More firmly established processes concerned in cutaneous aging are the degeneration of elastic tissue and the withdrawal of fat in certain areas in the subcutaneous tissues or what the ads call the "underskin." Since there is considerable debate over whether or not hormone creams improve the appearance of the skin at all, the effects will hardly be dramatic.

A controversy over the safety of hormone creams has been raging for some time. Many doctors feel that the use of hormones should be limited to treatment under medical supervision.

If you have any doubts concerning a piece of advertising in your newspapers or magazines, tear it out and forward it for comment to the Federal Trade Commission in Washington, the Committee on Cosmetics of the American Medical Association, 535 N. Dearborn St., Chicago, or your local Better Business Bureau.

BAYER ASPIRIN
CHILDREN'S SIZE
TABLETS

3 WAYS BEST
FOR YOUR CHILD

Each Tablet is Full Dosage

You no longer have to break a regular size aspirin in half to give your child the "half an aspirin" doctors often prescribe. Neither do you have to give your child more than one children's size tablet. For each Children's Size Bayer Aspirin tablet contains *half* the amount of regular size Bayer Aspirin.

They're Mistake Proof

When you give your child Children's Size Bayer Aspirin, you know it is genuine Bayer Aspirin because each tablet is stamped with the Bayer cross.

You Can Give Them With Confidence

Mothers give Children's Size Bayer Aspirin to their youngsters with complete confidence—for they know that Bayer Aspirin's single active ingredient is so gentle to the system that doctors often prescribe it even for the smallest children. 30 tablets, only 25¢. Buy a package today.

WATCH YOUR CHILD GROW

EATING IS FUN

by MARION O. LERRIGO

EATING is fun. Certainly, but why bother to mention it? Doesn't everyone like to eat? Daddy comes home from work looking forward to a good dinner, and Mother, though she has prepared the meal, will enjoy it too. Fortunately for Daddy's peace of mind, the battle to get Junior to eat his carrots is over—win, lose or draw—and Junior is subdued and in bed before Daddy gets home. Junior, it seems, doesn't like carrots.

So eating is fun, but not for Junior? No one knows how many little children behave as if eating is not fun, but lately experts have rallied to their cause. They say every little child has a right to enjoy his food. If your child is one of those whose every meal is a battle, the experts have some sound suggestions for restoring peace to your home and good cheer to your own and Junior's meals.

"Children like to eat" and "Children will eat if you *let* them," the National Association for Mental Health states in its recently revised pamphlet. "Eating Problems of Children," a guide for parents. The same subject is covered for doctors and nurses in a companion piece, "Eating Patterns of Children." The pamphlets were written in 1943 by Dr. Nina Ridenour and now have been revised by her in consultation with other child development experts. The pamphlets may be obtained free from many state health departments or mental health authorities, or, at 15 cents each or less in quantity, from the National Association for Mental Health, 1790 Broadway, New York 19.

"Good food, offered in a friendly matter-of-fact way, without urging: there—as simple as that—are the main points in helping children to develop good eating habits," Dr. Ridenour points out. The pamphlets develop the idea that a healthy child wants his food, and adults need only set the stage so that the child can enjoy it. The mistake that probably causes more complications than any other is forcing a child to eat, either by subtle pressure or heavy-handed discipline. "You can't *make* people enjoy something. You can only *let* them enjoy it. The parent's job is not to make a child eat, but to let him eat."

"Might there not be some rather serious hazards in following such a policy?" I asked her. "At one point you say that children do better if they are fed when they are hungry and given the amount of food they seem to want. Isn't that a little carefree?"

"There are hazards in following any policy of child care to the extreme," Dr. Ridenour replied. "We hope that parents will use their own common sense. The dangers in the permissive approach arise when parents don't understand what they are trying to do, and don't really know how children develop. One mother I know was so extremely permissive in her attitudes that she never even encouraged her child to eat 'just a bit more,' though he was clearly underweight, and a medical examination showed very poor musculature. She didn't realize that the child needed support and guidance."

Dr. Ridenour has pointed out in these pamphlets many of the most important things that parents should know about the growth of children in relation to their eating habits. For example, it is hard for parents to realize that their baby or young child is probably a pretty reliable judge of how much he needs to eat. "A baby knows how much milk he wants," Dr. Ridenour writes. "The doctor knows from long experience approximately how much the baby will want during any given period of his growth. But the baby knows—even better than the doctor or the mother—exactly how much he wants at any given feeding. When he leaves a little in his bottle, he is showing you he has had enough."

Grownups readily admit that they like their food better when they are hungry, but there was a time, not so long ago, when no one thought of applying such a rule to babies, who were fed every four hours on the dot, regardless. Times are changing in this respect, and in fact, the newest edition of the Government's best seller, "Infant Care," says boldly, "Babies know when they need to be fed."

These new theories of "self-demand" feeding have confused some parents, Dr. Ridenour says, and it is helpful to them to know that if the baby is fed when he is hungry, he will probably develop a fairly regular routine suited to his own needs. In fact, some routine is needed, both as training for the child and for the mother's convenience. A "flexible, orderly routine," allowing for common-sense variations as needed, is the most satisfactory way.

"I want my child to learn to eat everything," many a mother has declared, but the experts now advise the adoption of somewhat less lofty ambition. "Children, like adults, have their food preferences," Dr. Rid-

"Mother knows best" is not always true. The child knows how much to eat. Guide her, but let her be the judge.

enour points out. Ten to one Mother and Dad don't eat everything! If Junior won't eat carrots, there are also peas, squash, greens and beets. "The best way to get a child to like all kinds of foods is not to try to make him eat all kinds against his will, but to give him some freedom of choice," says Dr. Ridenour.

The baby's introduction to solid foods, which now comes as a rule at the age of two or three months or even younger, is a critical period. The baby has to get used to different consistencies, and he has to learn to swallow without sucking, instead of sucking and then swallowing. Dr. Ridenour says that many babies find it much easier to take some kind of fruit such as apple sauce, instead of cereal, as their first introduction to solid food, and potatoes are es-

pecially difficult for some of them.

Is there any danger that giving solids to babies at such an early age may create difficulties? I put that question to Dr. Samuel R. Berenberg, chief of the infant and preschool division of the New York City health department, who worked with Dr. Ridenour in revising the pamphlets.

"On the contrary, it is better to start early," he said. "Children who do not get solids until later often have difficulty. Sometimes they develop an aversion to lumps, and pick out every lump from their food. You needn't worry about starting too soon, for if the baby isn't ready for solids, he simply won't take them."

Of course, the atmosphere and the setting of the meal are important for its enjoyment, and most mothers appreciate the value of pretty dishes, colorful food and cheerful voices. Perhaps not all of them have realized that even babies are sensitive to the emotional climate of mealtimes. "Babies need a lot of loving, and one of the times when it is most important for them to feel happy and loved is while they are eating," Dr. Ridenour says. Mothers should make the change from the breast to the bottle as easy as possible for the baby. "Cradle him in your arms, cuddle him, hold him closely so that he will feel loved and happy."

Mothers often worry needlessly when the baby starts to eat less at about 1 year of age. The reason is that he is growing more slowly and much less. Thinking that because he is bigger, he needs to eat more, the mother tries to force the baby to eat more than he wants and unwittingly lays the foundation for later complications in his eating habits. The child of 1½ to 2½ years, said Dr. Ridenour, is likely to go through a negativistic phase of behavior that may carry over into his eating habits. Dr. Berenberg observed that two year olds are likely to be very fond of meat, but to dislike vegetables most sincerely. "They soon learn to crave sweets, too, but should have as little as possible."

Asked about the hazards of the "permissive" approach in child feeding, Dr. Berenberg said, "The greatest danger is over-permissiveness of parents. For example, children should not be allowed to run around all over the house while they are consuming their meals. And they certainly should not be allowed to eat their meals while watching TV."

In response to the comment that some children who have been poor eaters will eat their meals happily while watching television, Dr. Berenberg explained: "The practice is completely contrary to all that we pediatricians have been trying to teach parents about child feeding. Eating is one function that should be pleasurable in itself. Children need to learn to chew and taste their food with appreciation of its goodness. Moreover, when the child sits in isolation, so absorbed in the adventures on the screen that he doesn't have the least idea what goes into his mouth, all the cultural values of mealtime are lost. You might as well dump everything into one dish and give him the sort of potpourri they used to feed the poor children in orphanages! And what happens to the social advantages of eating in company with the family? The youngster needs to acquire the good manners that put him at his ease socially; needs to benefit by all the socializing influences of a good meal, attractively served, in good company. Of course there will be exceptions for some extraordinary program now and then. And don't mistake me—I like television, but not with meals!"

"When we first had television, the children wanted to watch it during their meals, but I put my foot down," said a mother in my neighborhood. "I thought that if I went to the trouble of cooking a good meal, the family could sit down and enjoy it! And we want our family together at meals, for it's one time when the children can visit with their father. The children understand why we want them to eat at the table, and they don't mind waiting until after the meal to watch the program. Now and then on Sunday evening, we all have sandwiches together while we watch a program we all want to see, but that's something special."

So, eating can be fun for children, without any artificial props to make it exciting. "Your own common sense is the best rule," Dr. Ridenour concludes, in "Eating Problems of Children." "In general, it is best for your child if you try to understand how he grows and what he needs, and then do what seems most sensible to you. When in doubt, avoid extremes. Take the middle course."

"Romantic, heck! This was the only way I could get here."

Captain Lewis L. Millett Medal of Honor

When his Infantry company was pinned down by heavy fire near Soam-Ni, Korea, Captain Millett charged alone into the enemy positions, throwing grenades, and clubbing and bayoneting the enemy. Inspired by his example, the attacking unit routed the Reds, who fled in wild disorder.

"It's an uphill struggle," says Captain Millett, "to build a working peace. Unfortunately, the only argument aggressors respect is *strength*. Fortunately we've learned this lesson in time.

"*You* can help build our strength—the defense-line of peace—by buying United States Defense Bonds. Every Bond is a declaration to the world—especially to would-be aggressors—that we aim to insure peace.

"I think a secure peace is worth working for. If you think so, too, buy U. S. Defense Bonds now!"

★ ★ ★

Remember that when you're buying bonds for national defense, you're also building a personal reserve of cash savings. Remember, too, that if you don't save *regularly*, you generally don't save at all. Money you take home usually is money spent. So sign up today in the Payroll Savings Plan where you work, or the Bond-A-Month Plan where you bank. For your country's security, and your own, buy United States Defense Bonds now!

Peace is for the strong... Buy U. S. Defense Bonds now!

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HEALTH ON THE BUDGET

Forethought on family finance protects mind and body, pocketbook and pleasure.

by EILEEN BURKE

A HEALTHY budget can be as good as a raise, but it's more than that. It's a positive plan for health and happiness. It's a plan for financial health to balance income and outgo; and it's a plan to promote physical health for the family. Certainly it is not a plan for skimping or doing without.

A healthy budget is custom-made for your mode of living. Its essential principle is setting aside some current income for future expenses. It's flexible, to accommodate emergencies or changing needs. It is simple and realistic, based on family sharing. Above all, it points toward the goals you really want, whether they include college for the children, vacation in Mexico or membership in the country club.

So unless you're satisfied that you're extracting the maximum from each dollar, call a family council to determine whether your income won't buy more. If you want a budget mapped for having, not doing without, ask the family, and your conscience, these questions:

How much money comes in? When? The more irregular your income, the greater help a budget. Are you living this month on this month's income?

How much did you spend last year? On what? What are fixed expenses, such as mortgage payments, rent, insurance, taxes? When due? What must be set aside each month to meet them? Do you have an emergency cash fund?

Do you know what you want, both week-to-week and long-range? It's easier to save when you have a definite goal.

How's your buymanship? Do you confuse the best with the most expensive? Do you know when a markdown is a bargain and when it's an extravagance? Do you realize that stores add their services to every price tag? Do you know how to buy sheets, shoes and spades?

Do you understand installment buying, loans, charge accounts and other forms of credit? Do you know how much credit costs? If you can't be trusted with charge accounts, are you honest enough to admit it? Do you realize that your credit depends on past performance, and intention and ability to pay?

Does all the family share in the planning? A budget needs everyone's loyalty. Johnny must grasp why Mary's braces come before his bike; all must agree on the choice between a new refrigerator and a new lawn.

Are the proportions allotted to savings, food, housing and so on reasonable? There's no rule; they depend on your income and inclinations. But think it over before spending more than one-quarter on housing. A smart neighborhood, where you're underprivileged, means increases in other departments, from children's allowances (they want to keep up with the Joneses, too) to entertainment and garden tools.

Does "miscellaneous" sabotage the budget? Who ever saw $10 worth of "miscellaneous"? Find out what it is—magazines or movies or birthdays—and label it.

You're probably wondering what all this has to do with a healthy budget. And asking if a sound

BARGAINS IN FOOD ESSENTIALS

WHAT	FOUND IN	SAMPLE BARGAINS	OF INTEREST
Protein	Meat, poultry, fish, dry legumes, cheese, eggs, nuts, cereal, bread, milk	Dry beans and peas, dry milk, variety meats, oatmeal, peanut butter	Protein needed daily from varied sources for they supplement each other. Medium eggs better buy when one-eighth cheaper than large.
Phosphorus	Whole grain cereal and bread, cheese, milk, legumes, meat, fish, eggs, leafy greens, chocolate, nuts	Evaporated and dried skim milk, chard and turnip greens, legumes	Buy cheese in bulk. Mild cheese cheaper. Aged cheese differs in flavor but not nutrition.
Calcium	Milk, cheese, figs, oysters, greens	Evaporated and dried skim milk	Milk bought at store cheaper than home-delivered
Iron	Meat, enriched and whole grain cereals and bread, molasses, dried fruits, fish, greens	Chard and spinach, prunes, potatoes, enriched bread and cereal, molasses	
Vitamin A	Butter, fortified margarine, liver, greens, yellow vegetables, dried fruits, cantaloupe, peaches, eggs, cream, whole milk	Fortified margarine, carrots, kale and beet greens	Insist on margarine fortified with A. Tub butter a good buy if refrigerated.
Niacin (B complex)	Chicken, variety meats, enriched and whole grain cereal and bread, yeast, fish, lentils, corn, peanuts, cantaloupe	Stewing hens, whole grain and enriched bread and cereals, peanut butter, canned salmon	1 lb. fish fillets equals 2 lbs. whole fish in edible food.
Riboflavin (B complex)	Meat, milk, eggs, leafy greens, dried legumes	Dried skim milk, dried limas, rutabagas and mustard greens	Hard nutrient to get cheaply except in skim milk. A dozen eggs costing less than 1 lb. boneless stew are better value nutritionally.
Thiamine (B complex)	Enriched and whole grain bread and cereal, pork, variety meats, eggs, fish, dried legumes, green and yellow vegetables	Enriched and whole grain bread and cereal, pork, dried peas and beans, potatoes	Use cereals to get milk down adults.
Ascorbic acid (Vitamin C)	Citrus fruits, tomatoes, leafy greens, cabbage, strawberries, cantaloupe	Canned or frozen citrus or tomato juice, potatoes, cabbage, spinach, kale	All fresh, raw vegetables and fruits containing some C. Easily destroyed in cooking.
Vitamin D	Fish liver oils, vitamin D milk	Sunshine (if available), vitamin D evaporated milk	

budget guarantees health. The answer, of course, is no. A budget won't keep bones from breaking; it won't prevent measles.

Nevertheless, a balanced family economy contributes to your health. Set-asides for regular visits to dentist and doctor can prevent physical and financial pains. Small sums for keeping the home safe prevent accidents. A cash surplus is conducive to a good night's sleep. There are just a few fortunate souls who can ignore money. Most of us may know where the next meal is coming from, but a new overcoat or real estate taxes involve figuring and finagling.

The basic contribution that a shipshape budget can make to health is good eating. Budgeting food allowances doesn't insure good nutrition—and good nutrition doesn't insure health, but it is the most important single factor in physical well-being. You can eat healthfully on less than you'd believe. The secret is knowing nutritional bargains.

A third of our best-fed nation needs more vitamins. It's cheaper to purchase them in groceries than across a drug counter. (There are exceptions; your doctor can tell you about them. If your climate ignores sunshine, you need vitamin D milk, fish oil or vitamin D capsules.) Lack of proper nutrients may explain those vague complaints—indigestion, fatigue, nerves—which you can't pin down.

Most mothers know the "basic seven" food groups, though they don't always apply their learning. They know that each day they should serve leafy green and yellow vegetables; citrus fruits; milk; whole grain or enriched breads and cereals; potatoes and other vegetables and fruits; butter or fortified margarine; meat, fish, poultry or other protein.

That food pattern can be provided extravagantly or cheaply. A smart housewife can substitute time and skill for money. Time substitutes for money when she goes out of her way to shop at a supermarket, or concocts a tasty casserole from inexpensive ingredients. Skill substitutes when she juggles flavors and nutrients.

(And husbands should note that there's nothing like frequent vocal appreciation to spur on a culinary artist!)

If feeding your hungry horde demands more money than it should, or if you'd like to cut food costs to indulge in other extras, here's how to start.

1. See the chart for nutrition bargains. There are cheap proteins and expensive ones. Compare newspaper and radio ads. Plan menus before you shop, but be versatile enough to switch when stew meat is cheaper than the fish you wanted. Buy more dry beans and peas, potatoes, enriched bread, whole grain cereals for home cooking, cheaper greens and fruits in season. Buy less choice meat, poultry and garnishes; they're costly food values. Don't cut recommended amounts of milk, since it's an economical food, but cook with evaporated or dried skim milk. Skip fancy bakery goods and bake at home, tucking in extra nutrients such as dried skim milk and soya flour.

2. Shop when the stores aren't crowded. When there's no line shuffling behind you, you're more exacting with the butcher and can watch his scales. Fresh produce is choicer early in the day. If time dictates marketing by phone, look until you find a dependable store, but remember that you pay for service and

delivery. Learn average prices, so you can recognize bargains.

3. Read labels. Look for enriched or whole grain breads and cereals, to supply the B vitamins. Most states now require such enrichment of bread and flour and, in the South, of corn meal, too. All processed food in interstate trade must bear labels giving net weight and contents, so you can compare two cans of tomatoes for cost per ounce. Don't confuse manufacturers' adjectives with grades of the U. S. Department of Agriculture, which are identified as U. S. standards. Mature vegetables and fruits go into U. S. grades B and C. Maybe not so rich in syrup, or so eye-perfect, they are frequently more nutritious than fancy grades.

4. When you find a product you like in a nationally known line, you can rely on a consistent effort to keep it uniform, and often you will find that brand a good lead to other products that suit your taste. But you may find a better buy among local brands, or private brands of your store. If you trust the store, trust its brands.

5. Buy in quantity if you have cool storage space, and if the food keeps without losing vitamins. Buy in quantity, too, for freezing or canning bargains.

6. Meat in interstate trade must pass U. S. standards for processing from healthy animals under sanitary conditions. Packers, however, can label anything as "choice" or "fancy." Don't mistake their marks for U. S. standards. Ask to see the U. S. stamps on the carcass. Figure cost per serving, not per pound. Bone and gristle can make the difference between one and five servings a pound. Tenderness has nothing to do with nutrition. Try some cheap cuts, and variety meats—liver, kidney, heart—which are super food values, though the liver and kidney are no longer bargains.

7. Learn how to buy fresh produce; and to evaluate it against canned and frozen food, which has no waste. A small blemish may cut price but not value; while old beans, or apples or oranges with wholesale decay, are no bargain. Use the outer celery stalks; turnip and beet tops. Frequently, there's more nourishment in what you toss out than in what you eat.

8. Buy in season. Strawberries are cheaper in June than in April, and grapes in October than in March. Frying chickens are good buys in late summer; older hens in the fall. Beef comes to market in October, and in February and March; pork from December through the spring.

Step up egg-buying in the spring, nuts in the winter; milk and dairy products in May and June. When heavy production hits local markets, prices tumble.

9. Consider a garden, for delicious, vitamin-full eating, and for preserving. There's quite a thrill in growing your own, as well as exercise and balm for the budget. If space is limited, devote it to the expensive fruits and vegetables your family likes, not the cheap ones.

10. Canny shopping and superb cooking are wasted if food isn't stored correctly. Dairy products need darkness plus cold to preserve values. If food needs cooling, don't buy more than the refrigerator holds. Dampness rots dried foods. Variety meats spoil faster than the muscle cuts, so use them quickly. Don't store cake, cookies or crackers with bread. Potatoes, onions, apples and other produce stored without refrigeration do need a cool, dark spot. Salad greens and perishable vegetables belong in the refrigerator in a hydrator or plastic bag. Exposure to heat and air is hard on vitamins; most of them are also water-soluble.

11. Spice low-cost meals with seasonings and herbs. Develop a flair with left-overs and meat extenders. If your husband refuses hash—or a favorite equivalent, for they are legion—patiently explain the correlation between roast beef and his "Where did that ten dollars I gave you go?"—and improve your hash recipe. For less shrinkage, cook meat slowly, at moderate temperatures. Cook with as little water as possible, and don't overdo. Then use the water—it may have absconded with half the vitamins and minerals in the carrots. Steamed vegetables retain maximum food values. The brief cooking time and little water needed by pressure cookers save food values, if you follow directions. Cooking root vegetables in the skins also conserves nutrients.

12. Set a good example to the youngsters by polishing off your milk, and chewing on raw carrots and whole grain cereals. That's supremely important with the high school crowd, which may be feeling that milk and carrots and cereals are kid stuff. Set the example of a solid breakfast and an adequate lunch.

13. Dine at home, not in restaurants. If father or children must buy their lunches out, consider switching to box lunches you can prepare.

The budget's food quota depends on prices, family size, and how efficiently you operate. It depends notably on how many ravenous ten to fifteen year olds you have, and it depends on your attitude toward food. To some, a delicious meal is a stirring event; fine eating is an entertainment. To others, one meal tastes

just like another. Either way, a varied diet is basic to flourishing health.

To avoid big dental bills, the first step is intelligent eating. Ration the intake of sweet drinks and candy—acids produced by sugar fermentation in the mouth cause decay. Diabetic children on a low-sugar diet, for example, have little tooth decay.

The second step is faithful brushing, right after each meal if possible. Cheap enough, so don't regard a tooth brush as a long-term investment. Buy a new one often. A dentifrice just reinforces the brush—baking soda does just as well.

The third step is budgeting for regular, preventive visits to the dentist. Serious tooth trouble can often be forestalled by diet and dental care. It's not safe to wait until the tooth aches. A set-aside of $5 for examination now may save $100 next year.

Nor is it safe to wait until children's permanent teeth come in. Start the youngsters early on a regular schedule—and ask the dentist about the fluorine treatments which cut decay in young teeth. Adhere to a schedule yourself; a small cavity is cheaper to fill than a big one. You can manage—the average woman spends more on her cosmetics than on her teeth.

Time payment plans for major bills, along lines worked out by the Detroit Dental Society in 1941, have now been adopted by a number of dental societies. Most dentists will set up a reasonable schedule of payments. Orthodontic work, like a denture or a major overhaul, can be a stunning blow to a modest budget. It's worth extra tugging to fit bills into the budget, however, since malocclusion is a factor in eventual loss of teeth.

You don't have so much control over medical expenses as over dental bills, but again, diet and the stitch in time are basic. You can avoid fatigue and overexposure; self diagnosis and patent medicines. Regular check-ups are important. In too many families babies rate regular examinations and in-between trips to a pediatrician at the first sign of a sneeze or an ache; while the father, who provides the wherewithal, and the mother, who keeps the family operating, neglect themselves. Health, like the budget, is a family affair, and all of the family will suffer when the mother or father is ill.

Obviously, a chronic illness requiring long hospitalization, such as cancer or tuberculosis, or a catastrophic accident, can ruin the healthiest budget. It may drop your family into the "medically indigent" class (solvent except for medical bills) or perhaps it just wipes out savings. Comparatively minor expenses can make you cancel vacation or the new television set. Actually, during any one year, one out of three families has almost no medical expense, and another pays only minor bills. But the heavy bills are apt to fall on the young, or elderly families, least able to carry the load.

A major illness may be the gravest financial problem you'll ever face. You can't provide for the bills completely, but you can, build a cash balance to discharge some of them. You can partially insure yourself. Although hospital charges are only about 25 per cent of the nation's medical bill (and although Blue Cross pays only about 80 per cent of the hospital bill), more than 75 million people find that hospitalization insurance is a good buy. More than half own a policy with a local

Blue Cross plan; most of the other half are insured with private insurance companies. About 5 per cent belong to consumer-sponsored plans and employee benefit plans. The more liberal the benefits, the higher the premiums. When you subscribe, check your benefits—how many days in the hospital, extra services or drugs, nursing and so on.

About 52 million people also invest in surgical insurance, and about 18 million in medical insurance. Benefits vary, but Blue Shield surgical and medical plans pay up to two-thirds of the doctor's bills. A few insurance companies are experimenting with policies for catastrophic illness. And in a few years, perhaps, you can buy dental insurance; such a plan is about to start in New York.

Insurance against loss of income through illness or accident is available. Four states—New York, Rhode Island, New Jersey and California—have compulsory programs for such coverage. More than 34 million workers have such insurance, through trade unions, paid sick leave systems or commercial policies. These do not reimburse for medical expenses, but they do furnish income while the worker isn't earning.

Nationally, we lavish as much on liquor as on total medical care—doctors, dentists, hospitals, nurses, drugs—combined. Sustaining good health and paying for poor health claims about 5 per cent of the national income. Why don't you budget 5 per cent of your income to maintain family health? Incidentally, the Bureau of Internal Revenue recognizes this average, and allows medical expenses in excess of 5 per cent of income as a deduction.

There are other ways to budget for health. We're not selling electricity—but please don't scrimp on lights. Nature designed our eyes for outdoor work, by day; we force them to do close, detail work, at all hours, indoors. Good lighting won't improve eyes, but it can reduce strain. Reading close print (often part of children's homework), concentrated sewing on dark fabrics—even applying makeup can cause strain if there isn't enough light. The danger hour is twilight, so light up early. Turn unused lights off, but remember that extra switches, which save crossing an unlighted room, may also save a broken shin. If you want to pare light bills, paint your walls a pale color, to reflect light. Dark paints absorb light.

Another false economy is neglecting home repairs. It may lead to accidents and doctor bills. Tab a few dollars in the budget for safety upkeep and replacement.

As homemaker, you're responsible for the family—so you must stay well. It's stretching the imagination to claim your health demands a dishwasher—but modern, energy-saving equipment certainly helps you avoid fatigue. So does knowing how to use the dishwasher—or how to save steps with the old dishpan routine.

Imagine That!

Whenever his guilt is patently clear,
Our brash, ingenious little youth
Is perfectly ready to volunteer
A fine explanation, or the truth!

Thomas Usk

Webster defines recreation as a recreating; "refreshment of strength and spirits after toil; diversion, play." It's one facet of health, but opportunities, whims and talents vary so that no one can recommend budget allotments. Your favorites may be inexpensive, such as bridge or a stroll in the countryside. Or they may be expensive—photography or golf. The same sport or hobby may be cheap in one town and costly in another. If your hobby eats up cash, try to make it pay for itself. Investigate the free facilities in town—classes or programs at a library or museum; public pools or beaches or tennis courts; groups gathered to enjoy a mutual interest, be it birds or badminton. Develop a hobby quite different from your daily routine, one that relaxes tension and releases pent-up feelings.

If you didn't balance your ledger last year, and drew on savings or went into debt, you're not alone. More than four out of ten families kept you company. Having company won't keep you from worry, but a balanced budget will contribute to your mental health. Consider how many nights you've tossed, trying to maneuver, figuratively, among the Christmas bills and installments on the car and the insurance. When you can't make income equal outgo, family tensions multiply. Money isn't everything, but there is a visible relationship between a prosperous budget, peace of mind, and a happy family.

How children feel about money depends markedly on their parents' attitude. Constant quarrels or constant anxiety about money can embitter them, and result in their putting too exalted a value on dollars. But sheltering children from family financial facts is just as pernicious; and so is sacrificing all for their sake. The shock they'll collect in the outside world will be fierce. If youngsters don't learn early how to handle money, they'll mishandle it later.

Include them in the budget council. Grant Billy an allowance at an early age, with an explicit understanding as to what it covers—carfare, school books, lunch, movies, Sunday school, and so on. Make it generous enough to cover a small sum over and above necessities, to disburse as he pleases, with no questions. Soon you can introduce the novel idea of saving, when he covets cowboy boots that cost more than his weekly free-spending money. Let him discover that setting aside a few coins each week builds a fund for the boots. Surprise him with a treat every so often. And remember that Billy, too, needs a raise when his obligations increase. Handling his money teaches him to make his own decisions. If he's continually overdrawn on his allowance, ask yourself what example the family sets. How's your budget?

Responsible handling of income, over the long stretch, is one sign of emotional maturity. Everyone has bad years, when illness, unemployment or family crises create such pressure that the budget blows up in your face. A solvent financial background helps you face that crisis calmly and hopefully. You can draw on savings and credit. And there's nothing like a healthy budget to help you achieve that state of solvency and well-being.

Coke & TV

At home

SERVE Coca-Cola

When they pause for station identification, *the pause that refreshes* with ice-cold Coca-Cola is as near as your refrigerator. Get it, serve it. Ice cold—right in the bottle.

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How We Learn to See

(*Continued from page 24*)

vision conflicts with Cyclopean single vision. Such a situation is particularly annoying, for the frustrated attempts to see singly lead to eyestrain accompanied by headache, nausea and even vomiting.

Even in normal people, temporary double vision resulting in eyestrain develops when the fusion mechanism becomes overtaxed. Such is the case in continuous near work as in sewing, writing or reading, when the eyes must accommodate and converge to maintain fusion. Poor illumination aggravates eyestrain because it reduces the strength of the optical stimuli which set off and keep up the fusion reflex.

How can we observe the development of fusion in our children and what can we do to help it? The baby's first attempts to see with both eyes often frighten the young mother. She is afraid her child will become cross-eyed. Often it looks that way, for infants are "cross-eyed" until they have mastered the art of binocular vision. Up to 4 to 6 months they look at objects once with one eye and another time with the other eye. When they are nearly half a year old they occasionally look at their hand with both eyes simultaneously. It is their first endeavor to fuse the retinal images. After such attempts they relax their eyes again and appear cross-eyed. The more they practice the effort to fuse, the more conspicuous is the "cross-eyedness" when they relax. In some babies the difference between eye positions in fusion and in relaxation is so marked that the mother becomes gravely disturbed and consults her physician. This *alternating* cross-eyedness in the first year is, however, mostly a transitory state of development which each child must pass through till binocular vision becomes stronger and finally takes over.

What then, are the factors that may disturb the normal development of fusion? First of all one must consider all conditions which cause a poor projection of light on the background of one of the eyes. If one eye receives a clear image of the world, but the other a fuzzy one, then the two images cannot be successfully combined into a single mental impression. This happens when one eye has good vision and the other is far-sighted or near-sighted. It is often difficult to discover this condition in children of preschool age. They do not complain about blurred vision in one eye because they mentally suppress the indistinct image and actually see only with the clean, dominant eye. Frequently it is only the persistence of cross-eyedness beyond the age of 2 which leads the parents to consult their doctor. Often he discovers then that one eye needs correction by a suitable lens to achieve distinct vision. As soon as both eyes see equally well the two retinal images may become fusable. If glasses are fitted *early enough* these children have a fair chance to acquire satisfactory fusion power.

Other factors which prevent single vision are of a more complex nature. They are disturbances in the development of the eye muscles and the nerve-muscle coordination. To determine and remedy the cause of such defects requires detailed study of each case and is often difficult.

Let us, however, suppose that no visual disturbance is noticed in early infancy. What can we ourselves do to help a normal development of binocular vision? The approach to this question can be guided by a principle which Roman physicians advocated 2000 years ago. They said the first duty of a physician is *nil nocere*—not to harm. Applied to vision it implies that we must avoid everything which interferes with the *natural* development of good fusion. Most injurious to normal development are poor illumination and continuous near work. Experiments have shown that it takes only a fraction of a second to fuse the images of both eyes when the illumination is favorable, but that it takes several seconds with poor illumination. The effect of reduced illumination is usually associated with the eye muscle strain of near work.

These two factors have become progressively more important with the advent of modern industrial civilization. But a few generations ago a large sector of mankind completely changed its mode of living. Before that, man lived predominantly outdoors. His visual apparatus developed to meet the demands of nature consisting mainly of distant vision with bright illumination. The visual axes are parallel in distant vision and outdoor illumination amounts to several thousand foot candles. Indoors, near vision forces the eyes to converge and the brightness level is reduced to a few foot candles. It is evident that the change-over from outdoor to indoor life and strenuous near work has an unfavorable effect on the development of binocular vision, particularly when we expose small children to it in school.

Numerous surveys have shown the detrimental effect of indoor life upon vision. They indicate a striking relationship between occupation and visual defect, for example the lowest percentage of visual disturbance is found in farmers, the highest in draftsmen. Defective vision leads to poor scholastic work. It has been shown that grade school children, normal in their studies had few visual defects (14.6 per cent), but 85.4 per cent of those retarded in their studies had defective vision.

What attempts can be made to cut down influences which overtax the visual apparatus? Caught in the web of our complex modern civilization, we cannot escape by "return to nature," as Rousseau advocated, unless we are willing to give up its comforts and gratifications. All we can do is to try to ameliorate its drawbacks.

The visual learning process should be facilitated by good illumination and ample opportunity for relaxing distant vision. Modern child specialists agree that early and extensive outdoor life is not only wholesome and invigorating but also the best preventive for eyestrain and defective vision. This does not mean that defective vision in itself is always brought about by external factors, but a disadvantageous environment unquestionably increases the chances for aggravating visual deficiencies.

To put it bluntly, outdoor life should start in the cradle. Especially in cities infants are kept indoors too much, where illumination is but a few foot candles and walls inhibit eye muscle relaxation. Kindergarten youngsters should spend a great deal

of time outdoors and the time spent indoors playing with small objects and looking at pictures should be held at a minimum. Children should be outdoors in winter as well as summer except in actually inclement weather. Early to bed, to avoid inadequate artificial light, and early to rise for utilizing daylight, is a time-honored prescription.

The latest "gift" of civilization, television, is of questionable value for our children's eye development. In its present state of limited technical perfection it can become visual poison for them. Prolonged watching of a close screen with scant illumination results in poor fusion. It easily overtaxes the children's eye muscle coordination. Sensible moderation in exposing children to this type of entertainment is in order.

When school age approaches let us not be overly ambitious in prematurely coaxing our children into an ordeal which may not be commensurate with their physical capacities. Within reason, the later the better! Small script and bad posture in reading and writing place an additional burden on the eyes by aggravating the strain of near vision. Good illumination for school and home work cannot be overemphasized. "Certified lamps" provide sufficient diffuse illumination of the surroundings combined with direct light on the working area. Due consideration should be given to the child's vision in choosing his future occupation.

The question often arises whether eye exercises will improve weak binocular fusion. The value of such exercises, called orthoptics (meaning "right seeing"), has been the subject of much controversy ever since they were introduced a hundred years ago. Their purpose is to develop skill in coordination of the eyes' nerve-muscle apparatus. They help to correct bad seeing habits, but they should not be regarded as the one way to correct cross-eyedness. Only in those cases in which orthoptic exercises succeed in establishing correct seeing habits with both eyes will they lead to its disappearance. If orthoptics are used only when strictly indicated the results will be gratifying; otherwise they will be gravely disappointing.

by CARL J. POTTHOFF, M. D.
First Aid Director, American Red Cross

EXPOSURE TO COLD

Exposure to intense cold causes progressive injury to body tissue. The skin color changes from a red appearance to white or grayish yellow; then blisters appear, and finally the skin and underlying tissue become necrotic (lifeless). Often the victim is not aware that freezing is occurring.

Clothing containing multiple air spaces impedes heat loss effectively. Several layers of woolen fabric provide such insulation. An outer garment of leather or substitute material to shield against the wind is an important additional safeguard. For the feet boots should be snug but not tight-fitting. Two pairs of woolen socks may be worn; the inner pair should be changed often. Wet clothing permits rapid heat loss.

What to Do

1. FROSTBITE. A badly frostbitten extremity should be warmed gradually. Leave the part exposed at comfortable room temperature. Elevate the extremity slightly. If tissue seems badly damaged call a physician; meantime do not apply a dressing, but guard against contamination. In the field, however, apply a dressing if a sock and shoe must be worn.

2. FREEZING. For frozen face or ears, place the warm hand against the part.

3. Do not apply an antiseptic; washing with soap and clean water is better. Do not rub the area, for example with snow, nor apply a hot water bottle.

4. CHILLING. In case of severe whole body chilling, put the victim to bed at once, covering him adequately. Give warm fluids, and keep people with colds away.

FOLD ON DOTTED LINE AND MAKE A FIRST AID FILE IN YOUR RECIPE BOX

It must be borne in mind that eyestrain, suppression of conflicting retinal images and defective vision leave their mark on the mental development and social adjustment. They contribute to frustration, lack of self-confidence and nervousness. We shall earn ample reward if we offer our children a fair chance to develop their nerve-muscle coordination for proper binocular vision and depth perception by exposing them adequately to those stimuli which outdoor nature supplies.

Preview of Birth

(Continued from page 45)

this stage awake. I had not known that the real pains would cease, but had jumped to the conclusion, as so many women do, that it simply got worse and worse until the baby was born. I had had a light anesthetic with the others but with this one I was jubilantly wide awake and aware of what was happening.

"Doctor, I have begun the second stage," I called.

He came quickly and looked at me. I was taken immediately to the delivery room.

"Can you get on the delivery table by yourself?" he asked.

"I think so," I said as I crawled across to it.

I watched, between pushes, while the nurse strapped my knees over the knee rests. When my wrists were strapped to the table it felt wonderful to have something to pull against as I bore down with my contractions. Then the pubic area was sprayed with antiseptic to make it sterile.

"Wait, Mrs. Welsh. Don't bear down any more," the doctor called. He was rushing into his mask and gown. I remembered a trick I had read on how to keep from bearing down. I panted like a tired puppy and miraculously the contractions waited. As soon as the doctor swung around the end of the table, pulling on the last glove, and said, "All right," I pushed hard and the baby's head was born. Then once more and I felt the little bo 'y being lifted out and I popped up on my elbows to ask eagerly, "What is it?"

"A girl," I was told and the doctor held her up. She was spotted gray with a cheesy looking substance called vernix caseosa and to me she was the most wonderful thing I had ever seen. I watched, spellbound, as she was laid across my abdomen and the cord was cut and tied. She made a few noises and was whisked away to a table to be wrapped up in a blanket.

"Lie down and push once more," the doctor instructed me. I pushed and the afterbirth was born. The third and last stage of labor was completed. I popped up again to see the afterbirth. It was larger than I had imagined and was a mottled purple.

At that moment my baby emitted a loud, resentful howl that was sheer symphony to my ears. I lay back down once more to be cleaned up before going to my room. When I was ready I took the doctor's hand and slid off the table and walked out into the hall. I felt wonderful—as if I had not even had a baby. This time there were no stitches. A small incision, called an episiotomy, had been made with the other babies to prevent a ragged tear. But with this one I had been able to control the contractions and allow time for the tissues to stretch slowly and without strain.

I climbed onto my bed, which was waiting at the door, and rode triumphantly to my room.

"Hi, honey. I'm hungry," I announced.

I told my husband we had a new daughter and he went to round up something for me to eat.

While he was gone, the nurse came in with some medicine for me to take to help my uterus start going back to normal. She felt my abdomen and gently kneaded it to see that the uterus remained contracted.

The doctor came in to see that I was all right and to congratulate me on the accomplishment of my mission. I begged to see the baby once more, for I had not seen her after she was cleaned and dressed. He smiled and said he would ask to have her brought in as he left.

My husband finally returned with some cheese and crackers and stayed until I finished them. It was late then and he had to leave so he kissed me goodbye.

When the nursery nurse came with my baby, I touched the tiny hand and looked into the wrinkled little face and I felt the same wonderful thrill of elation and awe that mothers have felt down through the ages. She was no Miss America but she was mine and to me she was the most wonderful baby in the world.

The Little Doctor

"The wonder is not that the liver pill will find the liver and the heart pill will find the heart; but that the patient has faith that they will."

Peter J. Steincrohn, M.D.

Saturday Afternoon

(Continued from page 33)

The tiny, tight grip that he'd had on his nerves snapped. He thought of the mountain spires in the Philippines rushing at him and panic seized him. He was on his feet, stepping out of the toboggan, when he heard Jim Marshall shout, "Charlie—sit down! We're taking off!"

It was no use. He couldn't do it. He'd nursed his special fear so long now—

And then he heard Steve's cry. He turned. Steve had leaped from the toboggan. "I've got a stomach ache or something, Dad," he said in a thin, pinched voice. "It's awful. I had it all afternoon but I didn't admit it. You got to take me home, Dad. Now. Right away."

Charlie Spence stared at his son and wanted to crawl under a snowdrift. Steve looked angry and Steve looked hurt. But Steve did not look sick.

Charlie said, "Hold it just a minute, Jim."

Then he walked over to Steve and put his arm around Steve's shoulder. "You'll be all right, Son," he said. "You just sit down and wait here. We'll ride down and if you're not feeling better when we get back, then I'll take you home."

"But Dad—"

"Wait, Steve," he said. He jumped into the front of the toboggan and he did not look down the chute. He turned his head and said, "Let's go Jim."

Then they were off, rocketing down into what seemed to be pure space. The wind was a thin-bladed knife on his cheeks. His heart was a mallet against his chest, and the earth, he was sure, was a planet they'd left far, far behind.

But they hadn't. The roar in his ears died down as he felt the angle of the toboggan smooth deliciously out. The unbelievable speed of their snubbed craft snapped, as though someone had started pulling from behind with a rope. He opened his eyes and saw they were bouncing pleasantly across smooth field, gliding slower and slower, until finally they came to a stop.

They all jumped out and Charlie Spence stared up the hill. It didn't look so steep, really. He watched another toboggan race merrily down —and he felt an eagerness to get up there and do it all over again. And then, at the very mouth of the chute he spied a small, familiar figure waving his arms violently.

"It's Steve," he said. "Let's get back up there, Jim. I think he's feeling better—probably ready to ride down with us." He grinned at Jim and added, "This is certainly the way to spend a Saturday afternoon."

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Ethel Jacobson

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Protecting Health in Disaster

(Continued from page 27)

out remuneration to give typhoid or tetanus serum, when necessary, to people in the stricken areas.

The Civil Defense and Disaster Corps, under Drs. Ralph Duncan and Carroll P. Hungate, were ordered to stand by should Civil Defense volunteers be needed in the emergency. Fortunately, it was not necessary to call out this large group. But, again, it was comforting to know they were standing by.

In Her Own Field

To her a curtain is a curtain,
Not a drape,
With a certain purpose and a certain shape.
She never wrote an article,
Presided at a garden club or turned a particle
Of clay or paint
Into something either modern or quaint,
Or hooked a rug or sewed a patchwork quilt,
Or loomed a shawl with a little thread of gilt.
Yet she's an artist!
No one will try
To equal her for golden apple pie!

Virginia Brasier

In the face of explosions and fires that devastated seven square blocks came such outstanding cooperation and preparedness that our feeling of security became even stronger. Ten local doctors, under the leadership of Dr. (and Lieutenant Colonel) Merritt H. Kimball, offered assistance as members of the 325th General Hospital Army Reserve Corps, and, along with them, 15 nurses and 35 enlisted medical personnel of the Corps were on duty for two days and two nights, giving first aid and medical treatment. It was a comfort for us to know that they came prepared with disaster equipment, in case the fires should spread.

Without charge, private ambulances and city ambulances worked around the clock, as did members of the public health nursing staff, and personnel of the 205th Naval Medical Battalion.

Under the direction of Drs. William W. Hart and Joseph W. Parker, Jr., the Red Cross was constantly on duty, giving supplementary medical and nursing service wherever and for as long as it was needed. In cooperation with the Safety Service Department, they set up first aid stations and shelters which they staffed throughout the emergency.

When the great fire was finally under control, no serious casualties had occurred—a master job in aid and protection. Kansas Citians were proud and secure in the knowledge that so much had been done and that so much more could have been done had the emergency spread.

The facts that I gathered seemed to whet my appetite for more details on how this gigantic system of health aid and protection had functioned here in Kansas City.

So I visited our city health director, Dr. Hugh Dwyer, and through him I gained access to the many bulletins, reports and press releases being compiled at the City Hall as part of the permanent flood record, which will be published and given world-wide distribution. I can readily understand the immense value this record will be to Kansas City and to you in other cities in the event of another disaster. All this material gave evidence of the cooperation among the many and varied health groups.

From Milton Tainter, executive director of the local Red Cross, I learned how these groups tackled the water situation, running water routes, carrying purified water to evacuees, firemen, police and other workers in the districts where no water was available. I learned how local companies donated tanks and milk cans and thermos jugs, ice, and trucks and other equipment. How Army engineers helped guard those tanks and water units. How the immunization program was shared by all. How doctors went back into many industrial plants after the waters had receded, to give typhoid serums. How Red Cross teams of nurses went into other factories to help relieve the congestion at the fixed immunization centers set up by the Health Department.

At the Jackson County Medical Society, I learned more of what had been done by private physicians during the disaster. As a precautionary measure, the medical profession and the private hospitals had wisely suggested a ban on all visitors at hospitals during the five day emergency water period. In order to relieve the heavy pressure at hospitals, they also requested that no elective surgery be done during that time. The private physician gave of his time and his service. In so doing, he also gave assurance to the people of Kansas City that all was well in health matters.

It was most heartening to find that during this great catastrophe, I, on the fringe of the devastated areas, had nothing to fear. And I had every reason for my feeling of security. I had every reason to put implicit faith in my community, in its citizens, and in the many private and public health organizations, all of whom brought Kansas City safely, health-wise, through the worst flood in its history.

Technical Ticklers

Here's a pleasant way to test yourself on words and meanings . . . just to let you learn privately whether you know things you should know. The following questions are based on information in this issue of *Today's Health*. Turn to page 65 for the answers.

1. What type of fabric slows heat loss from the body surface?
2. What common vegetable is a good source of vitamin C?
3. Why are color books not considered a good beginning medium for children's art?
4. Why shouldn't the "wonder drugs" be taken casually?
5. What is the present expected annual average of polio cases?
6. In which stage of labor does actual birth of the baby occur?
7. What are two principal signs of possible cancer of the respiratory tract?

Coming in Today's Health
Fluorides and Teeth
by Frank C. Cady, D.D.S.

They Won't Say Die

(*Continued from page 35*)

between 30 and 50, and develops and spreads rapidly. It is not inherited.

Henry, a public relations man for a motion picture company, and Frank, an advertising copy writer, have the second main form, called the juvenile or Erb's type.

Henry is 38 now.

"I was in high school, about 15 or 16, when it started," Henry said. "One day when I was combing my hair I noticed I was having a little trouble raising my arm. The disease was getting my shoulder and arm muscles. Then it spread to my neck. It grew steadily worse. My shoulders dropped as muscles of the shoulder girdle became weak and relaxed.

"Nothing much else happened to the other muscles of my upper body. But in one summer, in three months, my left biceps disappeared. MD got my legs too. It all took time. I was a great athlete, and I could still run a bit when I was 22. But then I had to give up most activities. In the last few years my legs have gotten worse.

"My father and sister have MD too. Dad got it late and his is an unusual case. He's 75 now, and he can still take a little walk now and then though every movement is difficult. But he keeps right on fighting."

The juvenile form of MD "goes fast when you first notice it and then seems to slow down," said Frank. "I can trace my trouble back to when I was 9 or 10. I'm 27 now.

"Looking back, I guess the first sign came when I was roller skating —I couldn't skate over rough pavement. I'd fall. I never said anything about it. But I was losing coordination and couldn't play games very well. When the guys chose up sides to play baseball or something I was chosen later and later . . .

"I was a junior in high school before my MD was diagnosed. If I tried to get out of a chair, I had to grab the sides and push myself up. Father went everywhere, even to England, trying to find treatments that might help me. I had vitamin E for a long time. It didn't do any good. I got B_1 and minerals by the mouthful, even various amino acids [the protein "building blocks"] and then thyroid and testosterone, the sex hormone. There was no effect from any of them.

"The disease has progressed so slowly that I can't notice any change day by day. Over two years or so you can notice changes by looking back to how you were then.

"Mainly it's my legs are affected. If I fall, I have a helluva time getting up. In winter I wear the lightest kind of coat so I'll have less weight to push up. I try to keep my body weight down for the same reason. My knees take such a beating from spills that I have a quarter-inch of scar tissue around them.

"There are no reflexes in my legs. They ache when I walk and my knees start to ache when I walk a few blocks. My hands are normal but there's some muscle involvement in my shoulders. I can't do the overhand crawl when I swim, but I can do the breast stroke.

"The disease is progressing very slowly in me. I consider myself immensely lucky."

Lucky!

In the small town in North Carolina, Billy Pinion grows weaker and weaker. Two younger brothers are dead of muscular dystrophy.

In the neat four room apartment of George Godfrey in New York City, four brothers are fighting muscular dystrophy. Redhaired Roy, now 22, was affected first. Eleven years ago he began to stumble in games of stickball. Then it became tougher and tougher to climb the five flights to the Godfrey flat. George, Jr., now 25, had no signs until after the war when he began having trouble climbing the ladders on the destroyer Sutherland out in the Pacific. The Navy sent him home.

Robert, 17, and Michael, 13, still go to school but muscular dystrophy is beginning to slow them up too. George takes jobs now and then to help bring in money, but, as with Roy, the sickness of growing weakness forces him to sit at home a lot. Mrs. Godfrey goes to work at 4 a. m. each day to clean floors in a downtown store. Her husband works nights as a waiter. None of the fam-

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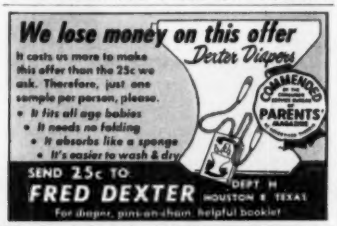

ily admit defeat—they're pinning their hopes on medical science to find something.

In Philadelphia the six sons of Mr. and Mrs. William Baird all have MD. But their two daughters have escaped it. For the Bairds the story began 11 years ago when Robert, now 20, began walking unsteadily. Today he cannot walk. William, 21, has MD lightly and works occasionally. Walter, 17, and Richard, 16, are fairly heavily hit, while Charles, 14, and Joseph, 8, go to school, but their gait is not steady.

In every state, in most cities, there are families whose children face early death or long years of progressive weakness and crippling.

"When we learned about muscular dystrophy, practically nobody was doing anything about it," Jess said. "Doctors had no answers. There wasn't a ray of hope."

In the spring of 1950, half a dozen mothers in New York City became acquainted. Each had a child so weak with MD that teachers had to come to their homes. Alone and singly, none of these women could strike back at the wasting disease. In unity, they reasoned, perhaps something could be accomplished. They asked the Board of Education to give them the names of others whose children have MD. They wrote to these parents, and called a meeting one April evening.

"Thirty parents showed up at the first meeting," Jess continued. "I heard about it on the night the second meeting was called, and hotfooted it over there. A hundred people were present, and then 300 at the third meeting."

These parents, rebellious at giving in to a vicious disease, formed the Muscular Dystrophy Association, to campaign for funds for research on cause and treatment. Word spread to other cities; now there are 62 chapters, in Pittsburgh, Boston, Los Angeles, Detroit, Philadelphia, Nashville, Akron, Ohio; Chicago, Louisville, Ky., and other towns. Frank spends many of his weekends flying to other cities to help organize new chapters. Last spring the chapters formed the Muscular Dystrophy Associations of America., Inc., which now has several thousand members.

Their goal for the first year is $75,000 for use in research. Later they hope to raise far more each year to finance research, to aid in setting up diagnostic clinics at hospitals, and to interest young doctors in specializing in MD.

Only a few hospitals or centers in the entire country have done any real research on muscular dystrophy. They have turned up some clues. And now the Association is financing seven research projects at five different centers.

Apparently the best guess so far is that MD is due to some fault in metabolism, in the way that muscles use essential foodstuffs to get energy. The fault may be inborn, as indicated in the strong family pattern of the disease. It may also arise spontaneously in some people, or be a late appearance of an hereditary fault. Doctors have ruled out nerve disorders as a cause.

One clue came from animals. Rabbits get a disease resembling muscular dystrophy when they are deprived of vitamin E. Giving them vitamin E cures the disease. Vitamin E doesn't help human victims of muscular dystrophy — they don't seem to lack that vitamin. But there is a suspicion that the human disease may arise from faulty use of vitamin E or related chemicals.

One line of research is trying to learn how vitamin E is involved in the intricate chemical process by which muscles develop energy and do work. And to learn what may go wrong in muscular dystrophy.

At New York Hospital-Cornell Medical Center, Dr. Ade T. Milhorat and a staff of chemists and other specialists are making and testing a series of compounds resembling Vitamin E and the other chemicals involved in muscle activity. Each one is tested on human beings after laboratory studies show that it is safe and that it might fix the broken chain in the human muscle action.

A valorous young woman is a volunteer human proving ground for many of the parade of new compounds and chemicals. She is Rose Maisel, blue-eyed, dark-haired, attractive, the heroine in an amazing medical record, adding to human knowledge because of what she eats.

Nearly every day for eight years Rose has eaten exactly the same foods each day, never varying the prescribed diet a fraction of an ounce, never taking more, never leaving anything on her plate.

She does it voluntarily, to test the new drugs. The rigid diet means that she is always in an exact chemical balance, each day taking in the same amount of protein, fat, carbohydrates, fluids and other nutrients to build up body tissues and to supply energy. The physicians also know exactly how much of various chemicals are eliminated each day as waste products. Her chemical balance is so even that if any change occurs when a new drug is tried, the doctors know that the drug produced the change.

Muscular dystrophy causes muscles to lose too much of an important chemical compound, creatine. Each drug is tested to learn whether it reduces or prevents this loss, or gives other signs of making the chemistry of her muscles more normal.

Probably no one in history has voluntarily stuck to a rigid diet as long as Rose has in these metabolism studies. Each September she reports to the hospital and lives there until the summer when the metabolism ward is closed down for six weeks.

Rose's daily diet is three eggs, or more accurately it is a certain weight of eggs equaling three average eggs, some cereal, frozen peas, canned pineapple, coffee with sugar, bread and milk, American cheese. It is nourishing, but deadly monotonous.

Her only possible variety is to decide to have the cereal for lunch instead of breakfast, or to have two eggs at one meal. In the fall, as the day's fare is mapped for the year, she may pick a different fruit. Whatever the choice, she will have it each day with no change for a year.

Never is there any meat, though Rose likes meat and she likes variety. Herself a victim of muscular dystrophy, with the form that begins early in adulthood, Rose sticks to her diet and the job is easier for "knowing that maybe I can help the doctors find the answer that will help so many people." Rose occupies herself with books, craft work, radio and television, and as a volunteer worker in the hospital's record room.

She often foregoes a special treat meal at Thanksgiving, Christmas, Easter or other holidays if Dr. Milhorat's team has a new drug to test. The slightest change in diet, or illness, affects her chemical balance and it may take several days to restore it. Rose doesn't want to see time wasted. For the same reason, she usually doesn't eat meat or alter her diet much during her summer "vacation," in order to be ready as soon as possible in the fall to resume the experiments. And, she says, the forbidden foods taken in the summer only make it harder to stick to the rigid daily fare.

Some of the experimental compounds show effect, enough to give encouragement, but so far none corrects the disease. Scores of other drugs, including the hormones ACTH and cortisone, have been tried. None helped.

Exercises often aid by keeping muscles going longer, or by training other muscles to substitute for the ones affected.

One gleam of hope is that MD affects only one kind of muscle, the striated muscles, which are very capable of regenerating and coming back to normal if the cause of the disease is discovered and corrected.

A goodly number of people may be walking about, troubled by muscular dystrophy, and not yet know it. MD, in fact, may not be so rare as

Answers to Technical Ticklers

(*See page 62*)

1. Wool. ("First Aid—Exposure to Cold," page 39.)

2. The white potato. ("Food and Health," page 38.)

3. The object is to foster expressiveness, not the ability to color exactly to the line. ("What Art Means to Children," page 18.)

4. Because casual dosings may make germs immune to their effects. ("Germs Fight Back," page 17.)

5. About 30,000 new cases. ("The Growing Polio Problem," page 28.)

6. In the second stage. ("Preview of Birth," page 44.)

7. Hoarseness and coughing. ("Self Inspection Against Cancer," page 22.)

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supposed, and there may be many unrecognized mild cases.

A main reason for the fatal outlook in most cases is that the disease has been so long neglected, said one physician who has specialized for years on muscular dystrophy. In past years the quick-killing and widespread infectious diseases engaged the prime attention of science and medicine. Only lately have the chronic and the rarer diseases got the attention they merit. The victims of muscular dystrophy suffered in silence, in isolation, and the cruelty and seriousness of the disease were hidden from the public eye.

These parents and sufferers from muscular dystrophy are determined to change that. Newborn hope is replacing the old despair. The victory may be a long way off, but they won't give in, and they're in the fight to stay.

Germs Fight Back

(*Continued from page 17*)

change to another drug. In this way it is possible to keep at least a step ahead of the germs.

Still another aspect of this problem is the fact that some families of bacteria have always been resistant to the new drugs. Though this may not be serious in itself, one eventuality can be a problem. If a patient harboring such a germ should be given a sulfa drug or one of the antibiotics, all the sensitive bacteria will be killed off or reduced in numbers. This will permit more luxuriant growth of the resistant strain by eliminating competition for food and room in which to grow. Again, this was demonstrated during the last war in various encampments where the new drugs were used to avert epidemics of meningococcic meningitis. The meningococcus germ, incidentally, is one of the few that have not shown any "fighting spirit": it has continued to be susceptible to sulfa drugs. But while these germs were being killed off in the camp personnel, other germs thrived and, as a result, there were epidemics of severe respiratory diseases, caused chiefly by certain pneumonia germs and a special strain of streptococci.

Acquired resistance is not always a simple process, and it may develop slowly. For that reason, there is not yet deep despair over treatment prospects in many conditions. Doctors have learned, furthermore, to give adequate amounts of the best drug right from the start. The "Sunday punch" is delivered in the very first round, not held off for some special time when invading germs may have been weakened or perhaps reduced in numbers.

Incidentally, many people have the mistaken impression that it is the body that develops a resistance to the drugs. The body may acquire increased tolerance for some medicines and require larger doses, but this does not happen with sulfa drugs or the antibiotics. The germs alone are responsible.

Second of the germ characteristics discussed by Dr. Garrod is the fact that some germs are or become dependent on drugs, principally antibiotics, for normal growth. In laboratory studies, it was found that such germs would not grow at all in the usual culture medium unless the specific antibiotic to which the germ had been exposed in a patient was present. But Dr. Garrod rejects the idea of treating infected patients by first giving the antibiotic and then stopping it, thus causing the germs to die.

Striking evidence of a germ's dependence on drugs was described in the *American Review of Tuberculosis*. Laboratory studies disclosed that certain altered forms of tubercle bacilli which depended on streptomycin for normal existence were present in colonies of the TB germ. Oddly enough, these wild strains were found scattered among forms of the germ that showed the customary sensitivity to streptomycin.

All sorts of special variants of germ sensitivity and adaptability have been recorded. A report made last September by Wallace E. Herrell and others of the Mayo Clinic, on a study of terramycin, described an especially unusual situation. These scientists first developed in the laboratory strains of germs that were resistant to terramycin, aureomycin, chloramphenicol and streptomycin, four important antibiotics. Next they tested the organisms to determine

whether resistance to one antibiotic meant resistance to all four. Surprisingly, there was a pattern of increased resistance to three, but not to the fourth, streptomycin. In fact, increased resistance to the three was often accompanied by greater sensitivity to streptomycin. The reverse was also true; streptomycin-resistant germs showed a decreased ability to resist the other three antibiotics.

Doctors recognized instantly the wisdom of giving patients combinations of such drugs, thus catching the germs in a cross fire of treatment from which they can't escape.

Dr. Garrod's final point, supported by other researchers, is that in some situations antibiotics may even cause germs to grow more rapidly and luxuriantly than they would under normal conditions. Obviously, this could be a serious matter. Although studies of this germ oddity are still incomplete, penicillin apparently is one of the worst offenders as a germ accelerator. Dr. Garrod cites, for example, recommendations of leaders in tuberculosis control that penicillin be avoided for TB patients because the tuberculosis germ seems to find that antibiotic an especially stimulating "treat."

All these findings have important implications for physicians and laymen alike. The former are alert to what is developing, and have succeeded in changing or combining treatment methods in order to continue the striking benefits that have already been obtained. And they have recognized that in certain situations they are giving the patient better medical care by withholding an antibiotic or sulfa drug.

The public, too, should know that casual taking of this or that sulfa or antibiotic preparation for a cold, sore throat or cough may be worse than unwise. It may spell the difference between recovery and the reverse if some disease such as pneumonia, influenzal meningitis, even an ordinary staphylococcal infection, strikes at a later date. For, in taking driblets of the wonder drugs from time to time, the patient can teach his germs how to develop strong resistance to—even dependence on—the very substances that otherwise would rapidly destroy them.

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by ELIZABETH B. HURLOCK, Ph. D.

Foundation for Life

THE FOUNDATION of the whole life is laid in childhood. If the foundation is good, both physically and psychologically, the chances are that all will be well throughout life. But if it is poor, the child will crumble under any unusual strain as the years pass.

In a house, a poor foundation can be mended or even rebuilt if its faults are detected in time. So it is with the health and personality of a child. But the bigger the superstructure of a house, the harder the repair job is. Similarly, in the child, each passing year means the deeper rooting of habits and the greater difficulty in uprooting or changing them.

Since childhood is a critical period, since the parents are responsible for laying the foundation of the child's life, and since the child pays the penalty in adult years if they fail to lay a good foundation, this responsibility should be accepted by parents as a sacred trust. It should be handled with great care, extreme conscientiousness, and with all the wisdom they can gain from experience and professional advice.

Some suggestions, based on professional experience with children whose personalities have broken under strain because of faulty foundations, may serve to guide parents in this all-important job of parenthood:

1. Be sure that your child has good physical care. Don't allow bad habits, especially those of sleep, elimination and eating, to persist in the hope that he will outgrow them. Since minor illnesses and defects may have far-reaching effects, not only on health but also on personality and mental efficiency, every effort should be made to keep the child in good health.

2. See that your relationship with your child is mutually satisfactory and happy. Since a child's first social contacts are with his parents, they should be made pleasant so the child will feel secure and wanted. This feeling will extend to other social relationships outside the home.

3. Give your child consistent training during the formative years. Sacrifice outside pleasures during this all-important time instead of turning him over to a series of nurses, babysitters, relatives and friends. Being taken care of by many people will cause confusion for the child because different people will expect him to do different things. Your child needs you to help him to establish good habits of behavior. No one can take your place.

4. Avoid making your child so dependent on you that he cannot stand on his own feet. Gradually cut the apron strings as your child shows he is ready and willing to handle the responsibilities you give him. Overdependence on parents can and frequently does play havoc with personalities as children grow older.

5. Help your child to establish healthy attitudes about himself, people, things, and life in general. Take time to discuss with him his point of view and see what it is. Many childish prejudices against people of different races, creeds and social status; many faulty attitudes about sex and religion; many fears concerning his own abilities; and many worries about his shortcomings can be avoided or corrected before they get a stranglehold—if they are brought out into the open, discussed frankly, and viewed through the older and wiser eyes of parents.

6. Give your child a happy childhood with plenty of laughter and fun. Doing this will depend less on your financial status than on your own attitude toward life. Help your child to learn to be a good sport and to take things as they come. Nothing will enable him to face life as successfully and as confidently as a proper perspective.

7. Give your child a sense of security. Even if family finances are strained, don't let your child know that things are insecure until he is old enough to face the fact philosophically. Security of family relationships is also vitally important to a child. Only when death brings about a break-up of the family should the child's family life be disrupted. Hold the family together at any cost for the child's sake.

8. Make your child feel at all times that he is loved for what he is.

On this page each month you will find a discussion of some significant phase of child development, from infancy through adolescence, with practical answers for specific problems. Address your questions to Elizabeth B. Hurlock, Ph.D., c/o TODAY'S HEALTH, 535 North Dearborn Street, Chicago 10.

Even when he is troublesome and naughty, he should have the confidence that you will be there to help him. Never let him suspect that he has not come up to your ideals or that you are disappointed in him. Young children sense when they are not loved or when another child is preferred. This produces a vague feeling of insecurity that colors their whole outlook on life and spreads to many seemingly unrelated areas of behavior.

Questions

FAMILY NAME. We have two children, a boy of 8 and a girl of 6. Both children were named for my wife's side of the family. My father thinks that, out of respect for him, our son should have been named for him. Can we do anything now to rectify our mistake?

Massachusetts

It is very late to consider changing your son's name now that he has reached school age. He has become accustomed to being called by one name. Changing his name would cause great confusion for everyone. It might be some solace to your father to add his name to the name your son already bears. But don't call the boy by this name unless he requests you to do so.

OVERWEIGHT. Do you approve of encouraging a fat child to be satisfied with his overweight to prevent him from developing an inferiority complex? California

Most decidedly not. If a fat child is encouraged to believe that it is all right to be fat, he will have no motivation to try to reduce. Furthermore, it is not all right for a child to be overweight. It cuts him off from the activities other children enjoy and this makes him feel inferior. In addition, the other children are likely to ridicule him and this may lead him to be antagonistic. He may find himself with no friends. A fat child should always be encouraged to watch his diet and, as an incentive to do so, he should be informed of how much his overweight is handicapping him.

Helpful Modern Points of View

Presented with the hope this will be interesting and helpful to you

What Are Your Child's Interests?

New 28-page pamphlet called "Sources of Free Pictures" lists hundreds of pictures, illustrated booklets, maps, charts that fit in with young people's hobbies and special interests.

If your child is particularly interested in any special subject at home, in scout work, his club or school—here's welcome news for you. Sources of Free Pictures, now available, can help add to his pleasure and knowledge. Helps give additional material for scrapbook, files, posters, projects—or even for pictures for young person's room.

The subjects are all arranged alphabetically. To give you the scope see box below. And here are subjects appearing just under "A":—Agriculture, Air, Airplanes, Alaska, Aluminum, Amphibians, Animals, Antarctic, Ants, Aquarium, Arabia, Art, Astronomy, Atomic Energy, Atoms, Australia, Automobiles.

Some of the Subjects which are Listed
Africa • Aluminum • Animals • Birds • Butterflies • Caterpillars • Chocolate • Conservation • Dairy Products • Frogs • Gardening • Interior Decorating • Jet Planes • Mexico • Oranges • Reptiles • Rubber • Sea Life • Textiles • Weather

Bruce Miller, the compiler, is Superintendent of Schools at Riverside, California. He began his first compilation of source lists for these free pictures as a hobby. And he says that there is no other source list just like this on the market today.

Included in the pamphlet are brief, easy to follow instructions on How to Start a Picture File and How to Mount Pictures.

The Pictures cover the thousand and one subjects boys and girls are most interested in today. And taken into account are youngsters in the Grades through Junior and Senior High.

In any such source list, Superintendent Miller knows it is impossible to include all the types of free pictures in America. Also, while each Source is verified, a manufacturer, trade, travel or government bureau might "run out". But if you tell what the pictures are to be used for substitutes can be made when it is necessary. Some of the sources are old magazines.

If you are further interested—This 28-page booklet SOURCES OF FREE PICTURES by BRUCE MILLER, Supt. Schools, Riverside, Cal., 50¢ postpaid. Write to BOX 369, RIVERSIDE, CAL.

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Books on health

Nutrition for Health

By H. F. Kilander. 415 pp. $3. McGraw-Hill Book Co., Inc., New York. 1951.

This is a good textbook on nutrition. It is useful for eleventh and twelfth grade and college level and as a reference book for anyone who would like to have a scientific, simply written, straightforward and sensible discussion of foods and nutrition and, what is more important, everyday eating, which is the only way to accomplish good nutrition through the sensible use of foods. Large, clear type and excellent illustrations add to the attractiveness of the book and enhance its usefulness.

W. W. Bauer, M.D.

The Nursery School: A Human Relationship Laboratory

By Katherine H. Read. 264 pp. W. B. Saunders Co., Philadelphia. 1950.

Children are people who develop healthy personalities more easily when they are accepted as they are. Acceptance, according to Miss Read, implies neither approval nor disapproval of the child's behavior in the nursery school group. It implies that the teacher, the parent and other adults associated with the child shall take the child as he is in any given situation and attempt to understand the cause of behavior before correction is attempted.

Throughout the book, the nursery school situation is used as a laboratory for the study of the child's relations to adults and other children with whom he must associate. The central theme of the book repeatedly stresses the adult understanding of the child's emotional reaction to each new situation he encounters and the guiding of the child into growth patterns that make him an acceptable member of his community.

This book is designed primarily for student teachers particularly at the nursery school level and has considerable technical material on psychology, emotional growth and development, and patterns of child behavior. This is well illustrated with many case studies. It is also a valuable reference book for physicians concerned with children in the preschool and early school ages and for parents who are sufficiently interested in the emotional development of their children to take the time and trouble to read a semi-technical volume.

D. A. Dukelow, M.D.

The Chicago-Cook County Health Survey

Conducted by United States Public Health Service. 1317 pp. $15. Columbia University Press, Morningside Heights, N.Y. 1949.

This 1317 page book, with 178 tables, 16 figures and 16 illustrations, is an audit of all the health facilities of the great metropolitan area of Chicago, which includes all the suburban and rural areas in Cook County outside Chicago and facilities

maintained by Cook County itself, an area in which 4,500,000 persons live.

At the suggestion of a group representing the health division of the Council of Social Agencies of Chicago, the Chicago Medical Society and the Institute of Medicine of Chicago, Edward J. Kelly, then mayor of Chicago, and Clayton F. Smith, then president of the Board of Commissioners of Cook County, were

asked to invite the U. S. Public Health Service to make an unbiased survey. Dr. Thomas Parran, then surgeon general of the Service, agreed.

The survey was divided into three over-all parts: environmental medicine, preventive medicine, and facilities and services for medical care. A brief listing of some of the topics covered will give at least some idea of the scope of the survey: water supplies, sewer systems and water polution, refuse collection and disposal, food control, smoke abatement, housing, communicable disease control, mental health, school health services, industrial health, medical care, nursing, ambulance services, clinics and outpatient departments and care of the chronically ill.

This survey of a large metropolitan area's health and welfare work shows not only the deficiencies of the government of Chicago in meeting problems for which average standards have been set on the national scale, but also the outmoded organization of modern government. Newer functions of government are often added to already existing governmental agencies without regard for their most efficient placement. This volume will be welcomed by all students of government—and by all of us who use health services and pay for them—because it outlines a true course of reorganization in modern public health. It can be compared to the Hoover Commission's report on the federal government. How soon many of these recommendations can be carried out is still a matter for our government to decide. The survey lays down the basic principles of health organization for the Chicago metropolitan area for the next ten years. If a majority of the recommendations can be accomplished by 1960—and some are already on the way—the survey will be a major success of modern government.

E. A. Piszczek, M.D.

How to Stop Killing Yourself

By Peter J. Steincrohn, M.D. 272 pp. $2.95. Wilfred Funk, Inc., New York. 1950.

Dr. Steincrohn has an enviable reputation for writing on medical subjects in a popular style. This book is his most ambitious, for in it he gives advice on many phases of physical and mental hygiene. He elaborates the theme that "the death instinct lies deeply buried in all of us," and then discusses the ways in which we are influenced by that instinct. Among these are self-treatment, failure to cooperate with one's physician, obesity, worry, overwork, envy of one's neighbors, the abuse of alcohol, drugs and tobacco and too much exercise.

In the dispensing of so much medical advice, there is always the danger that some of it may be taken too seriously or not taken seriously enough. Another pitfall is oversimplification. For example, Dr. Steincrohn's sweeping condemnation of sleeping medicines may make it difficult for a physician to persuade the patient who really needs such medication to take it without qualms.

The most helpful chapters are those on obesity, high blood pressure, exercise, worry and indecision, overwork and surrender to calendar age. There is a good deal of repetition in the book, and some parts might well have been pruned considerably. It should, however, help the intelligent reader to live more sensibly and, let us hope, to live longer.

Wingate M. Johnson, M.D.

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STUDENT No. 130

by
IRA H. KNASTER

It took a brave dean to submit this issue to a mob of students, but their answer made medical history.

THE young men were carrying on more like patients in a violent ward than students assembled to hear a medical lecture. On that particular afternoon—Oct. 19, 1847—their behavior was crude, boisterous and riotous; worse than on any day since the fall term had begun.

Standing next to his gruesome charts on the platform, short, pudgy, usually voluble Dr. Webster, professor of anatomy at Geneva Medical College, glowered at the packed amphitheater. He cast an especially acrimonious eye at the shenanigans in the top tiers where some of the wilder students were whistling, yoo-hooing and otherwise wolfing through windows that overlooked the campus of an adjacent normal school for young ladies.

At that moment, Dr. Charles A. Lee, dean of the faculty, strode into the lecture room. After a brief nod to the harassed Dr. Webster, he stood waiting for the bedlam to subside.

"Gentlemen," he said at last, "I crave your indulgence to be allowed to read an amazing letter our college has just received. I wish to preface my reading of it, however, by stating that this letter contains the most extraordinary request ever made to our faculty."

Completely intrigued, the students maintained a hushed silence until the Dean had finished reading. Then the dam burst; and what was bedlam before now became pandemonium. A hundred throats rent the air with catcalls, hooting and raucous, falsetto jests. Against this tumult, Dean Lee exchanged a knowing look with his colleague.

Then he quelled the uproar, shouting, "Gentlemen! A word, please! I want you to know that, as yet, we have taken no action on this letter. We have decided to leave the matter entirely in your hands, with this understanding: should there be even a single student who disapproves of this, er—highly unorthodox request, a negative reply will be returned to the sender."

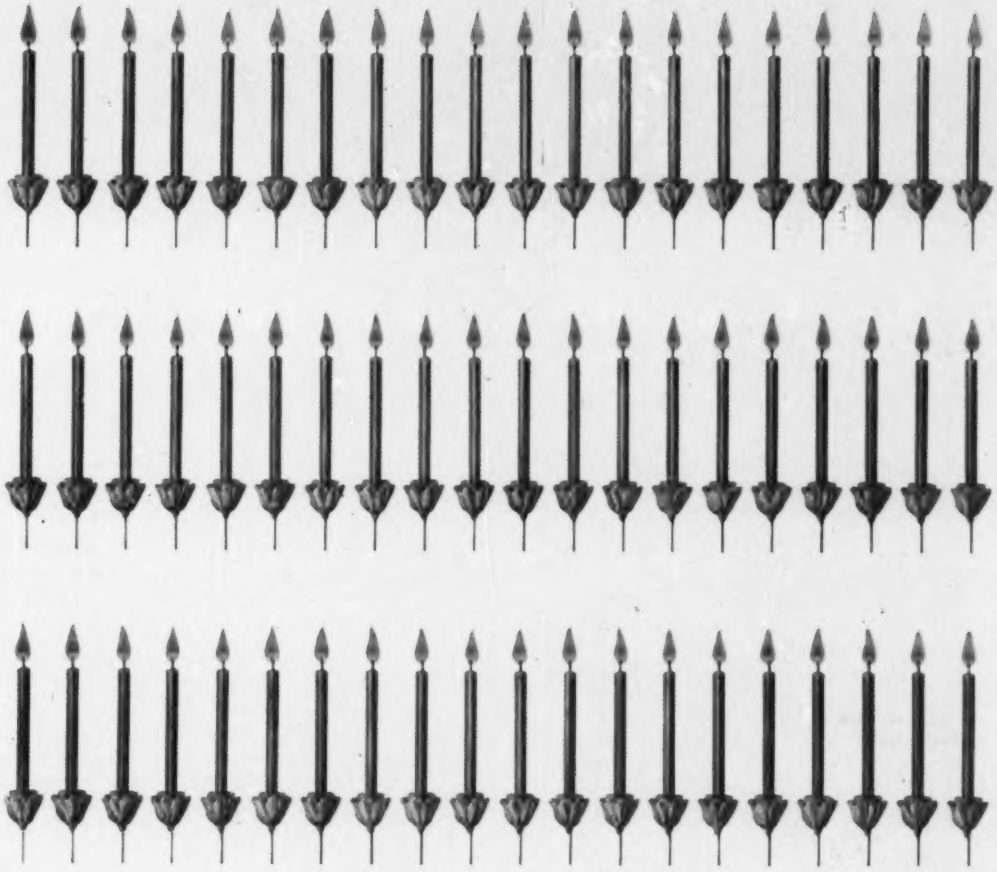
That evening the students held a meeting. Their conclave was a stormy admixture of the parliamentary and the Rabelaisian, the satirical and the sincere. From the welter of talk a resolution began to take shape; roughhewn, at first, torn by debate but finally crystallized and put to a vote. The "Yeas" welled up in a mighty chorus. Merely as a formality, the negative vote was asked. From one corner of the room a quavering "No" was heard but the lone dissenter fell hastily into line when some husky members of the majority moved threateningly toward him.

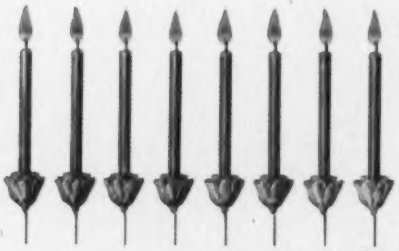
The students of that obscure Western New York college had acted—whether in the spirit of intellectual honesty or mere prankishness is not known for sure. But act they did, thereby shattering a precedent that had stood unchallenged since the time of Hippocrates. Dean Lee had no choice, and so he wrote an affirmative reply to the "extraordinary" request.

Two weeks later, when the incident was well nigh forgotten, things were normal again in the anatomy lecture room. That is to say, the usual state of zanyism held sway. While the several score future physicians awaited the arrival of their professor, they threw spitballs and tossed textbooks. They made ribald jokes. They flirted through the windows. In short, they behaved like a horde of hoodlums.

But suddenly Dr. Webster made his appearance—and every tier in the crowded amphitheater became a tableau as the students stared, open-mouthed. For, hand in hand with the rotund little professor, was a charming young lady, demure of manner, slight of stature and most attractive to look at.

"Why so goggle-eyed, gentlemen?" Dr. Webster inquired, poker-faced. "Have you forgotten your resolution? You can be sure this fair young lady hasn't. And she's most grateful for it. She has attempted to gain entrance in over a score of medical colleges. Until you men of Geneva responded so gallantly, her efforts had been fruitless. Yes, gentlemen, she is one of us now—registered here as student number 130. Let me present America's first female medical student and, I predict, first female physician—Miss Elizabeth Blackwell."





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In a way, the familiar birthday candles represent the most important—and the most gratifying—advance of our times. In 1900, the average man lived to see only 50 of them on his last birthday cake. Today, he can look forward to a cake with as many candles as there are on this page.

This added gift of years has been made possible by thousands of men and women who work together to make and keep our country the healthiest nation in the world—doctors, dentists, nurses, pharmacists, public health workers, and others. Their work has not only increased the span of life—it has also helped to fill these years with more useful and more enjoyable living.

One of medicine's greatest problems is to get people to take advantage of the help it can offer them. And *you* are the only one who can solve this problem. Remember, every time you act on a warning that may mean trouble—every time you take full advantage of medicine's resources to build, conserve, and restore health—you increase your chances of adding more candles to your birthday cake.

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